PUBLIC HEALTH NURSING

AUGUST
1952

Meat...

and the Prevention of Tissue Wastage in the Aged

Accumulating evidence indicates that insufficient dietary protein is an important factor in the pathogenesis of the tissue wastage frequently encountered in the aged. On the other hand, a sufficient intake of biologically adequate protein, such as provided by meat, is a potent factor in the prevention of this phenomenon.

Wastage of body tissues appears to be one of the most characteristic and obvious changes in the geriatric patient.[1] However, such tissue wastage in elderly persons is not entirely the result of a primary metabolic change or an accompaniment of old age. Clinical studies indicate that protracted negative nitrogen balance, stemming from the habitual consumption of inadequate amounts of protein, plays an important contributory role.

Recent studies of dietary practices among persons from 40 to 75 years of age suggest that protein deficiency is a most likely and a highly significant deficiency found in elderly people.[2,3] In a study concerned with nitrogen balance in healthy elderly men,[4] it was shown that diets containing 0.5 Gm. of protein per kilogram of body weight were incapable of maintaining the subjects in nitrogen balance. Increase of the protein to 0.7 Gm. established equilibrium. Since young adults usually maintain nitrogen equilibrium on a protein intake of 0.5 Gm. of protein per kilogram of body weight, this study indicated that aging adults may require at least as high or a higher protein intake for maintenance of nitrogen equilibrium.[1]

Meat merits a prominent place in the properly planned diet for the aged. Its rich store of biologically complete protein can play an important part in assuring nitrogen balance. In addition to protein, meat is also an excellent source of the B group of vitamins and of iron and other essential minerals. By physiologically stimulating the appetite and gastric secretion, meat promotes improved food intake and digestion.

1. Kirk, J. E.: Nutrition and Aging, Nutrition Rev. *9*:321 (Nov.) 1951.
2. Ohlson, M. A.; Roberts, P. H.; Joseph, S. A., and Nelson, P. M.: Dietary Practices of One Hundred Women from Forty to Seventy-Five Years of Age, J. Am. Dietet. A. *24*:286 (Apr.) 1948.
3. Kountz, W. B.; Hofstatter, L., and Ackermann, P.: Nitrogen Balance Studies in Elderly People, Geriatrics *2*:173 (May-June) 1947; Nitrogen Balance Studies Under Prolonged High Nitrogen Intake Levels in Elderly Individuals, ibid. *3*:171 (May-June) 1948.
4. Kountz, W. B.; Hofstatter, L., and Ackermann, P.: Nitrogen Balance Studies in Four Elderly Men, J. Gerontol. *6*:20 (Jan.) 1951.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

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PUBLIC HEALTH NURSING

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PUBLIC HEALTH NURSING
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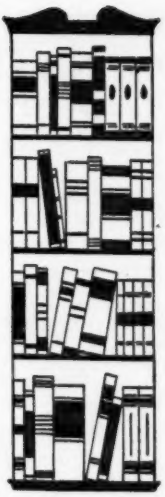
FOR PUBLIC HEALTH NURSES



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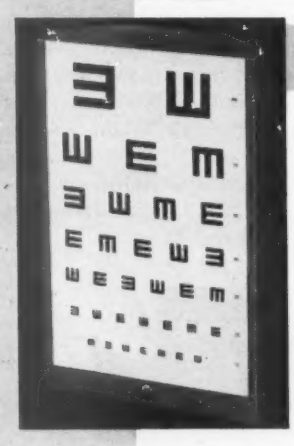
PUBLIC HEALTH NURSING is the official magazine of the NOPHN. At the Biennial Nursing Convention in June 1952 the membership of the NOPHN voted to dissolve the organization and transfer its programs and assets to the newly formed National League for Nursing. Until a ruling is received from the New York State Supreme Court the NOPHN must remain a legal entity and the magazine come out under its auspices.

In January 1953 the National League for Nursing's new official magazine, NURSING OUTLOOK, will make its appearance. This will continue the coverage of PUBLIC HEALTH NURSING and will also carry material in the overall fields of nursing education and nursing service.

Three Steps for Visual Screening in Schools



STEP 1

VISUAL ACUITY, the most important part of the screening program, can be done with greatest confidence with this chart, because the testing letters are accurate in size and shape, embedded between two sheets of hard plastic that can be washed repeatedly and are illuminated by a daylight fluorescent bulb and screened so as to produce an even distribution of 20-25 foot candles over the surface. (10 foot candles can be had on special order if desired.) Letter sizes 20/15 to 20/100 in children's E card or alphabetical card for 20 foot use. Also a reversed card for indirect or ten foot use with mirror.

Chart is 9 by 14 inches, comes complete with metal cabinet and bulb, ready to plug in. Weighs only 4 pounds and may be hung on wall or set on a table. Eye chart complete with children's E card.....$22.50
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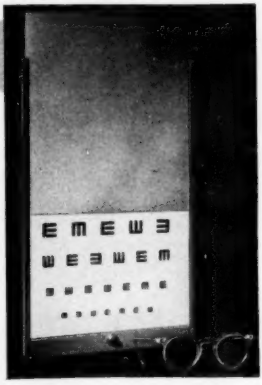
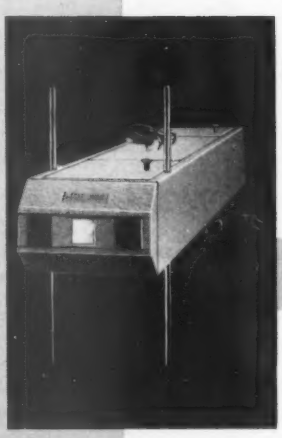
STEP 2



HYPEROPIA TEST, or far-sightedness test. This test uses the same chart, except the top lines are blocked off with a piece of cardboard showing only the 20/40 and smaller lines. Plus 2.00 glasses are used for fifth grade through eighth grade. About 10% of the children will be able to read the 20/40 line and about 3% the 20/30 line. Those that can read these lines are far-sighted and may be referred for correction if they are obtaining less than average grades in school. If children wearing glasses are screened, the plus 2.00 lenses are placed over their own glasses for the test.
Plus 2.00 glasses.....$8.00



STEP 3

MUSCLE AND SUPPRESSION TEST. This test is to detect about 2% of the younger children who have either poor co-ordination of their eye muscles or suppress or ignore the sight of one eye. This test need not be given every year and for that reason a special piece of equipment has been designed so that it may be shared by many schools, and thus not incur the extra expense for each eye chart. The advantages are that neither special Maddox rod glasses nor a dark room are required for the test. It is so simple to operate that even kindergarten children give reliable answers. This is important because it is in the younger children that the incidence is higher and the improvement from early treatment is most effective.

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PUBLIC HEALTH NURSING

Official Organ of the National Organization for Public Health Nursing, Inc.

NOPHN Resolves

THE MEMBERS of the 1952 Committee on Resolutions realized the seriousness of the task assigned them to incorporate into resolutions the ideas and desires of the NOPHN membership for presentation at the last membership meeting of the organization. Their task was simplified by the many thoughtful suggestions sent them.

Through these resolutions the committee has tried to accomplish two things. It attempted to identify for historical purposes the major contributions of the NOPHN. It also tried to select from the organization's many activities those of special significance which the members want particularly to be carried on in the future.

The resolutions were adopted unanimously by the members meeting together in Atlantic City on June 19, 1952. At this meeting the members voted to dissolve the NOPHN and transfer its programs and assets to the new National League for Nursing. Those resolutions which concern programs and activities will be referred to the steering committees of the divisions and departments of the NLN and, in some instances, to the boards of the NLN or the ANA. It is gratifying to know that the consideration given to membership resolutions throughout the history of the NOPHN will be continued in the NLN.

1. *Whereas,* the behind-the-scene planning and managing of a large convention demand long hours of hard work and meticulous attention to details; therefore, be it

Resolved: That we, the members of the National Organization for Public Health Nursing, express our gratitude to all those who helped to make this meeting possible—the New Jersey State Nurses Association, the New Jersey State Organization for Public Health Nursing, the New Jersey State League of Nursing Education, the local arrangements committee and its subcommittees, the convention bureau staff, the hotels, the ushers, the monitors, the messengers, the exhibitors, and the representatives of the press; and be it further

Resolved: That we extend to Emilie G. Sargent, our retiring president, our sincere appreciation for her untiring service. In a biennium that has made unusual demands upon a president, she has made generous contribution of her time, frequently traveling halfway across the country with little previous notice. She has shared her gift of incisive thinking with us all and has helped to facilitate sound planning during a period when momentous decisions affecting our profession had to be made. Her counsel has been founded on her years of experience and her large fund of common sense.

To Anna Fillmore and to the NOPHN professional and business staff who have smoothly carried on the daily, weekly, and monthly activities of the NOPHN while also entering into the planning for reorganization, which increased the difficulty of their jobs, we extend an especially hearty thank you.

We also are grateful to the board, lay and professional, and to the staff for keeping NOPHN members informed about step-by-step developments in national programs and projects during a complex biennium.

We have been fortunate in the quality of

leadership given us. It is the type of stimulating leadership that calls forth the best efforts of each NOPHN member.

2. *Whereas,* the responsibility for outlining a new organizational plan for nursing required tremendous vision, energy, and patience; and

Whereas, this difficult and important task was undertaken and performed successfully by a number of individuals; therefore, be it

Resolved: That we, the members of the NOPHN, express our gratitude to all who participated in preparing this plan, and particularly to Pearl McIver, chairman, Joint Coordinating Committee on Structure, 1950-1952; Hortense Hilbert, chairman, Committee on Structure of National Nursing Organizations, November 1946-May 1950; Josephine Nelson, public information secretary, Committee on Structure of National Nursing Organizations, 1947-1950; Ruth Freeman, chairman, NOPHN Committee on Structure, 1950-1952; and Edith Wensley, executive secretary, Joint Coordinating Committee on Structure, December 1950-1952.

3. *Whereas,* every step of planning for the structural reorganization has been weighed carefully by the NOPHN and every facet of the situation scrutinized by legal counsel so that the soundest possible organization might result; and

Whereas, this has required the continuous interest and attention of legal counsel; therefore, be it

Resolved: That we, the members of the NOPHN, extend our thanks to Mr. Edward H. Spencer for his guidance in all legal matters, and for his general practical direction; and be it further

Resolved: That we send to Sage, Gray, Todd and Sims, of which firm Mr. Spencer is a member, a note expressing our appreciation of Mr. Spencer's interest in our welfare.

4. *Whereas,* the Metropolitan Life Insurance Company and the John Hancock Mutual Life Insurance Company have for many years past made available public health nursing services to certain types of policyholders through cooperation with voluntary and governmental agencies; and

Whereas, in carrying out these services these companies have made a substantial contribution to the improvement of public health and to the reduction of deaths in all age groups and have compiled valuable and meaningful statistics; and

Whereas, in preparation for the approaching discontinuance of the above programs the Metropolitan Life Insurance Company has most generously loaned its personnel and resources for the purposes of strengthening local nursing services; and

Whereas, both these companies have furthered the work of NOPHN and promoted public health nursing services throughout the country; therefore, be it

Resolved: That the NOPHN extend to the Metropolitan Life Insurance Company and the John Hancock Mutual Life Insurance Company a vote of thanks for their valuable contributions to the fields of public health and public health nursing; and be it further

Resolved: That the NOPHN express the hope that both companies continue to share with public health nurses their statistics, health literature, and other materials; and be it further

Resolved: That we, the members of the NOPHN, extend our sincere thanks to all who contributed to these programs, to the officers of the companies, the staffs—nurses and others—and especially to Alma C. Haupt and Sophie C. Nelson for their untiring leadership.

5. *Whereas,* one of the most valuable, although limited, NOPHN services has been field consultation and advisory visits; and

Whereas, the period of availability of the staff loaned by the Metropolitan Life Insurance Company to the NOPHN comes to an end in December 1952; therefore, be it

Resolved: That the NOPHN investigate every possible means for continuing the field work program, at least in the amount given in the past two years, and if possible in increased amounts.

6. *Whereas,* many voluntary health organizations, such as cancer societies, tuberculosis associations, and others are concerned in seeing that sick people in the communities in which they raise their funds secure adequate nursing care; and

Whereas, we believe that one qualified nurse can best provide all the public health nursing

service needed by a family at a particular time; and

Whereas, we also believe that the organized nursing service in a community can best provide the nursing care needed by the sick at home; therefore, be it

Resolved: That the NOPHN continue to work with other national voluntary organizations to develop guiding policies for their local affiliates to use in entering into contracts with established local public health nursing services for home nursing care.

7. *Whereas,* there has been increasing interest in providing and expanding nursing service for the sick at home; and

Whereas, an increasing number of governmental health organizations are giving consideration to adding to their programs nursing services for the sick at home; and

Whereas, in some localities citizen groups are also giving consideration to developing public health nursing services; therefore, be it

Resolved: That the NOPHN work with the United States Public Health Service and the American Public Health Association and other national groups in reemphasizing the need for communitywide planning for the provision of such services.

8. *Whereas,* many public health nursing services have in the past decade entered into an increasing number of contractual arrangements with a variety of voluntary and governmental bodies to give nursing service to certain groups of people in a community; and

Whereas, these contractual arrangements have taken a variety of forms and have called for a variety of reports and frequently for a variety of elaborate billing procedures; and

Whereas, many organizations find that the preparation of such reports and financial statements requires as much or more time as the actual nursing service rendered; and

Whereas, such situations are administratively inefficient and generally unsatisfactory; therefore, be it

Resolved: That the NOPHN develop one or several types of forms for contractual agreement, and one or several types of invoices for services rendered; and be it further

Resolved: That every effort be made nationally and locally to promote the use of the standard forms in order that procedures relating to contracts for service may be simplified and standardized.

9. *Whereas,* the study of combination services in public health nursing was completed in 1950; and

Whereas, the published results have been helpful to communities throughout the United States; and

Whereas, many people have expressed the need for a study of public health nursing services in communities where such services are provided by both voluntary and governmental organizations; therefore, be it

Resolved: That the NOPHN seek the means to carry out such a study at an early date; and be it further

Resolved: That the findings of the study be published and given wide distribution.

10. *Whereas,* public health nursing functions are continually changing and expanding; therefore, be it

Resolved: That study and critical evaluation of public health nursing functions be continued.

11. *Whereas,* the membership at NOPHN's twenty-second convention held in May 1950 resolved to promote the inclusion of nursing benefits in medical care plans; and

Whereas, certain limited studies are under way and tentative plans have been made by NOPHN for a demonstration and study of nursing services in medical care plans; therefore, be it

Resolved: That the NOPHN go on record as advocating the continuation and extension of the existing studies and the institution of further studies of the need for and the role of the public health nurse in medical care plans; and be it further

Resolved: That the NOPHN express its considered opinion that qualified public health nursing personnel should participate fully in the planning and continuation of such studies; and be it further

Resolved: That we, the membership of the NOPHN, continue to work for and secure the support and interest of the public and of allied professions in promoting the inclusion of nursing services in medical care plans.

12. *Whereas,* there is an increasing need

and demand for public health nurses; and

Whereas, the total number of public health nurses being prepared has decreased appreciably in the past few years; therefore, be it

Resolved: That the members of NOPHN and the state and local public health nursing organizations increase their efforts to strengthen recruitment for public health nursing within the framework of the total program of recruitment for nursing.

13. *Whereas,* a continuously broadening public health program requires public health nurses to have new knowledge and develop new skills; and

Whereas, many public health nursing services have accepted the responsibility of providing inservice education as one means of improving service; and

Whereas, progress is being made in the development of more effective educational methods, technics, and tools; therefore, be it

Resolved: That the NOPHN and its constituent members continue to promote inservice education as a necessary part of a public health organization's overall responsibility; and be it further

Resolved: That NOPHN and its members study developments and practices in inservice education in public health nursing and encourage research in various aspects of inservice education.

14. *Whereas,* the United States of America is an active member of the World Health Organization and a participant in United Nations efforts toward peace and one world; and

Whereas, sharing of knowledge and experience is manifestly a powerful instrument in cementing peaceful relations; therefore, be it

Resolved: That we, the members of the NOPHN, approve the principle of international exchange of students in nursing education so that a broader mutual understanding of nursing problems and situations here and abroad may result.

15. *Whereas,* freedom to discuss controversial issues and ideas is fundamental to happiness and progress; and

Whereas, a profession in our society can flourish and develop only in an environment of free thought and free experimentation; therefore, be it

Resolved: That our organization do everything possible to promote free discussion of all issues which concern our profession and assume responsibility for wide dissemination of varying points of view on problems and programs relating to nursing services and nursing education.

16. *Whereas,* the functions of the NOPHN will be variously allocated under the new structure of the ANA and of the NLN; and

Whereas, the Collegiate Council on Public Health Nursing Education, a section of the NOPHN, will no longer exist in its present form; and

Whereas, the council members and the educational institutions which they represent have found the council a valuable medium for the exchange of ideas, discussion of problems, adaptation of educational philosophies, and planning of programs which have fostered continual growth in the field of public health nursing education; and

Whereas, the council has provided opportunities for meetings with nursing consultants of national public health agencies, state directors of public health nursing, and field teaching staffs of voluntary and official agencies which have resulted in productive discussions of common goals and the sharing of problems and their solutions; and

Whereas, the council has facilitated this interschool and intergroup communication, which has assured continuity of thinking and planning and has furnished support and promoted stability of collegiate programs in public health nursing; and

Whereas, it is the consensus of the group that such interchange of ideas and such support are essential to the optimum growth of collegiate public health nursing education; therefore, be it

Resolved: That the NOPHN recommend that provision be made for a comparable group of public health nursing educators to convene within the new structure.

17. *Whereas,* the Collegiate Council on Public Health Nursing Education, in joint session with the Council of State Directors of Public Health Nursing on November 6, 1948, recommended to the NOPHN that assistance

be given to collegiate basic schools in developing programs for the preparation of their students for beginning positions in public health nursing; and

Whereas, there continues to be a marked shortage of nurses qualified in public health nursing; and

Whereas, our philosophy of nursing education recognizes that the basic skills of public health nursing are part of the common background prerequisite to all professional nursing; therefore, be it

Resolved: That the Collegiate Council recommend to the Board of Directors of the NOPHN that continued assistance and encouragement be given to collegiate basic programs in nursing and to general nursing programs for graduate nurses leading to the bachelor's degree to further the inclusion in their curricula of basic public health nursing concepts and skills; and be it further

Resolved: That the accreditation of these programs as preparing nurses for beginning positions in public health nursing be implemented and expedited; and be it further

Resolved: That the Collegiate Council on Public Health Nursing Education recommend that studies by the appropriate group in the new structure be made of geographic needs in relation to collegiate and practice facilities as a basis for regional planning in the development of new programs.

18. *Whereas,* the Board of Directors of the NOPHN has made it possible to organize and to carry on the work of the Nurse Midwifery Section under its aegis; and

Whereas, this section was created at a time when many looked askance at nurse midwives; and

Whereas, during the six years of the section's history nurse midwifery has made an increasingly important contribution to maternity care in the United States and throughout the world; therefore, be it

Resolved: That the members of NOPHN go on record as thanking the Board of Directors for its decision to establish this specialty section in full awareness that to do so required foresight and courage.

19. *Whereas,* schools of nurse midwifery have been developed outside the walls of the hospital and the university; and

Whereas, graduates of these schools are making outstanding contributions internationally and on national, state, and local levels in this country in both voluntary and governmental services, in the field of public health, as well as in hospitals and in schools of nursing; therefore, be it

Resolved: That we recommend that education in nurse midwifery or obstetric nursing as a clinical specialty be included in nursing education programs within universities, with available clinical resources of a hospital where there is full acceptance of such a program.

20. *Whereas,* the NLN has now been organized; and

Whereas, there is need for state organizations to be affiliated with their parent organization for strength at both the national and state levels; and

Whereas, there should be continuity in services in the states and nationally and between national and state organizations; and

Whereas, model state bylaws will be available for guidance; therefore, be it

Resolved: That the NOPHN membership, public health nurses, and interested citizens, promote in every way possible the immediate establishment of state leagues for nursing and the reorganization of the state nurses associations—both of which involve public health nurses.

21. *Whereas,* the new NLN will need the support and interest of every public health nurse; and

Whereas, there are unprecedented demands for nurses which necessitate the most prudent use of the available nurses; and

Whereas, there is widespread interest in studying nursing functions and nursing education and in improving nursing service; therefore, be it

Resolved: That public health nurses and other citizens interested in total nursing give freely of their best leadership and support through membership in the NLN; and also that public health nurses join the new Public Health Nurses Section of the ANA.

22. *Whereas,* the founders of the NOPHN exercised great imagination in creating an organization that has made a unique contribu-

tion by demonstrating for the first time in a professional organization the fact that the development of community services requires the cooperative effort of interested citizens as well as that of professional workers; and

Whereas, the founders of the NOPHN also wisely laid down the principles and established the standards which have guided its practice for the past forty years, and provided a means for all people interested in public health nursing to work together toward developing and improving services; and

Whereas, by their initiative and generosity the friends of public health nursing made available funds which made possible much of the program of the young organization in a day when such funds were rarely available to professional organizations; therefore, be it

Resolved: That we, the members of the NOPHN, at this historic meeting express our appreciation of the foresight, initiative, and energy of the founders—particularly to Lillian D. Wald, the first president; to Mary S. Gardner, our honorary president, for her continuous, constructive contributions in solving the changing problems of public health nursing; and to the Honorable Frances Payne Bolton, friend and adviser, for her invaluable support; also, be it further

Resolved: That the nurse members express their appreciation to the men and women who, although not professionally concerned with public health nursing, have given so generously of their time, energy, and talent and who have become our colleagues in the truest sense as we work together to provide better public health nursing services.

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MRS. ROBERT S. WILKINSON, New York
ALBERTA B. WILSON, R.N., Pennsylvania
HEDWIG COHEN, R.N., *ex officio*
MARGARET L. SHETLAND, R.N., New York, *Chairman*

The 1952 Biennial Convention

EVERYONE expected the Biennial Nursing Convention to be a historic occasion and no one was disappointed. The actions of the more than nine thousand nurses and others who deliberated together from Sunday, June 15, through Friday, June 20, are already a part of the official history of nursing. They are also a part of the history of our times. The detailed reporting in the daily press proved how widespread was the interest in nursing and the outcome of the convention.

Two special forums on structure, scheduled to give everyone before voting began the chance to review all facets of the reorganization story and plans, were attended by capacity audiences. After Pearl McIver, chairman of the Joint Coordinating Committee on Structure, presented a background report the questions came thick and fast from the audience. It is not surprising that the first half dozen or so questions related to dues. So much had been conjectured on this subject that a good deal of confusion and uneasiness existed. Mrs. Elizabeth K. Porter, president of the ANA, and a member of the panel, summarized the situation in this fashion: "The amount of dues always depends on the amount of service. Think of dues as buying service from your organization rather than just as paying them to an organization. Dues can always be cut if we are willing to accept decreased services."

Someone asked about the value of agency membership — especially membership for schools of nursing and for hospital nursing services. Virginia Dunbar, dean of Cornell University-New York Hospital School of Nursing, answered: "I have long looked with an envious eye to services available from the NOPHN to public health nursing agencies and to the opportunities these agencies have to meet together to discuss their mutual problems. There is no area in which nurses need more help than in nursing services. It will be highly advantageous for nurses to meet with hospital administrators and lay people to discuss nursing service needs in hospitals. I am sure one reason public health nursing services have had greater public understanding is that they have brought in lay people to help them."

Louise Knapp, also on the panel, said, "Hospital administrators are as interested as nursing administrators in improving services. They have assumed that nurses can take care of their own problems and have concentrated their efforts on supporting the efforts of other departments in the hospital to improve their services. Nurses must be prepared to work closely with individual hospital administrators to secure their understanding and cooperation and to get them to see the value of membership in the Department of Hospital Nursing Services."

Someone wondered if there would be a tendency to join only one of the organizations since there is no requirement to be a member of both. Several of the panel members responded to this. The two organizations are companion organizations. They both need *all* nurses and all nurses need *both* organizations. The purposes are different and the opportunities offered to members are different. The nurse in the ANA helps to define professional standards for individual practice. The members of the NLN assume responsibility for seeing that policies and standards are carried out in an organized manner. The NLN offers the individual nurse the chance to sit down with her coworkers and with members of allied professions and interested citizens, including members of boards of trustees, et cetera, to determine how best to organize nursing services and nursing education. This is the first chance offered many nurses, particularly private duty and general duty nurses, to have a voice in such planning.

During the forums the announcement was made that the members of the American Association of Industrial Nurses at their annual meeting in April 1952 had voted not to dissolve their organization for the present. This means that the AAIN will not join with the other groups that transfer their programs and assets to the NLN.

The two forums did a great deal to set the climate for the NOPHN and NLNE business meetings and for the meetings of the ANA House of Delegates.

WHEN EMILIE SARGENT, president, convened the NOPHN business meeting early on June 16, there were members present from Alaska, Hawaii, Puerto Rico, and every state in the Union except Nevada—a truly wonderful turnout. Miss Sargent told of her great pleasure in being president at this time in the organization's history and expressed her gratitude for the privileges the position brought her. She did not mention the hard work that went along with the privileges, but all members know how well Miss Sargent has served them and the NOPHN as the last of its distinguished line of presidents.

After the preliminaries the membership considered the report of the Joint Committee on Structure and unanimously adopted the recommendations approving the general plans for the ANA and the NLN. Then the proposed bylaws for NLN were presented for detailed consideration. In introducing the bylaws Ruth Freeman, chairman of the NOPHN Committee on Structure, said, "Bylaws can never cover every contingency. It is the committee's hope that we can accept these bylaws as they are and next year, after we have had a chance to see how things work out, propose changes which may be needed. The main things are confidence in those we elect and the exercise of our voting privileges."

The NOPHN members unanimously accepted the bylaws, including approval of suggested changes made necessary by the decision of the AAIN not to reorganize for the present. A motion, introduced by Sophie Nelson, was

also unanimously accepted, to the effect that a committee be appointed to study the subject of making a place for qualified practical nurses and practical nurse education in the National League for Nursing.

Meanwhile NLNE members were holding their first business meeting also. For technical reasons the NLNE was chosen as the organization on which to build the new NLN. Therefore the members of the NLNE were presented with amendments to the original charter of their organization, which upon their acceptance would change the name of the National League of Nursing Education to the National League for Nursing and would change the functions to the broader functions of the NLN. The NLNE members voted in favor of these revisions on Wednesday morning, June 18.

And so the National League for Nursing was born.

The NLNE members in accepting the proposed bylaws for the NLN made a few changes. One of particular interest to the NOPHN membership concerned qualifications for officers. Article V, section 2, was changed to the following: Either a nurse or a nonnurse shall be eligible to hold any of the elected positions specified in section 1 of this article, except that of president and first vice-president. Only a professional registered nurse shall be eligible to hold office as elected president or elected first vice-president.

Ruth Sleeper, R.N., President NLN

When this was reported to the NOPHN, at the second business meeting on June 19, Mrs. H. Stanley Johnson, second vice-president of the NOPHN, asked to speak. She said that this change in the bylaws was understandable to her and to the other nonnurses, who realized that nurses would want their president and first vice-president to be nurses. She asked that "we not feel bad about this." Marion Sheahan immediately proposed a resolution stating that "while we accept the amendment restricting the position of first vice-president to a professional nurse it is our hope this restriction will be reconsidered in the future and that we spread upon the minutes of the meeting our opinion that NOPHN's experience with lay people has been a valuable one." This resolution was passed unanimously.

After the action of the NLNE members, establishing the NLN, it became incumbent upon the NOPHN membership to consider and vote upon the dissolution of the NOPHN and the transfer of its activities and assets to the new organization. This was carried out on Thursday, June 19. There were 4607 votes in favor and only one against the proposal.

Basically a membership corporation is a creature of the law. NOPHN was incorporated under the laws of New York State and final approval of the membership's action must be given by the State Supreme Court before the various processes of dissolving and transferring programs, et cetera, may take place. Therefore, pending approval, which may take up to sixty days, the NOPHN Board of Directors continues as a legal entity and services are continued under NOPHN auspices, so that no interruption takes place in them. The membership reelected the board members whose terms expired at the convention in order to facilitate this.

Incidentally, it took about three hours to count the ballots of those voting in person and by proxy. Recess intervals were called to permit people to see the exhibits and to get some lunch, but it was amazing how many

were on hand to hear the report when Miss Sargent introduced Mrs. C. Welles Belin, chairman of the tellers. (The other tellers were Alice M. Sundberg of Baltimore, Aline LeMat, New York, and Mary Breneman, Portland, Oregon.) Enthusiastic applause indicated the members' approval of the reported decision.

DURING THE convention the ACSN also met and voted to dissolve. Therefore, when Friday, June 20, 1952, dawned we were truly ready for the first meeting of the NLN. Agnes Gelinas, chairman of the Committee on Agreements of NLN, called the meeting to order and the invocation was given by the Reverend Arthur McKay Ackerson of Atlantic City. All then joined in singing the very stirring *America The Beautiful*. The election of the board of directors to serve until the NLN convention in June 1953 proceeded according to the initial procedure described in the bylaws. Also following specified procedure, the board retired and elected the officers. While waiting for the board to return to the platform congratulatory messages were read. These came from the AMA, the AHA, the American Cancer Society, the American Physical Therapy Association, the National Association for Mental Health, Community Chests and Councils of America, NFIP, NTA, National Health Council, National Social Welfare Assembly, American National Red Cross, American Psychiatric Association, National Society for the Prevention of Blindness and, among others, Lavinia Dock sent her loving greetings.

In a short time Miss Gelinas presented Ruth Sleeper, the first president of the National League for Nursing, who thereafter presided at the meeting. She introduced all the other members of the board who were present. (See page 467) In a few words she built an exciting picture of the tremendous potentialities for the good of organized nursing services and education which lie before us.

The NLN was ready for business! Miss Sleeper asked Ruth Freeman and Helen Goodale to come to the platform and discuss their ideas about practical nurse membership in the new organization. Miss Freeman said, "We in the NLN are concerned with nursing service as a whole—the broad field of nursing care our folks need, and how to get them the best possible care. How can we omit from such consideration the practical nurse? The practical nurse would bring us ideas and thinking we need. Since we must have such thinking it would be better to have practical nurses as an integral part of our organization."

Miss Goodale said she supported Miss Freeman's point of view but since NLN is embarking on the first perilous year she felt we should explore the question further before opening doors to practical nurse groups. In short order, members flocked to the microphones on the floor of the arena. Everyone spoke about the contribution of the practical nurses and in favor of admitting practical nurses to the NLN. The only point of difference concerned "when." There seemed to be a strong swing toward immediate inclusion, but Miss Sleeper reminded the members that to do this demanded a revision of the bylaws and this would require a unanimous vote. Therefore it was resolved that the fact be spread upon the minutes that the NLN membership approved in principle the inclusion of

Anna Fillmore, R.N., General Director, NLN

qualified practical nurses as members of the organization. Another motion, requesting that the NLN board set up a committee to work with appropriate practical nurse groups to bring in recommendations for action at the next convention (1953) was passed. (Such a committee was established by the NLN board on the following day.)

Professor Ashley Montagu of Rutgers University addressed the first meeting of the NLN on the meaning of cooperation. He really held his audience enthralled and we hope to be able to bring you his complete talk in an early issue of the magazine.

Before adjourning the meeting Miss Sleeper announced that the board had appointed Anna Fillmore general director of the NLN.

THIS REPORT is getting very long and you may be wondering if the whole convention was structure and NLN. Surprisingly, many other things happened. For example, throughout all the intense bustling about the NLN the ANA House of Delegates carried on its own exciting session. Every nurse some time in her career should have the opportunity of being a member of the House of Delegates. This year the doors were opened to visitors also, and the experience must have been a revelation to many. We can all be proud of the nurses who represent us in the House. They prepared themselves through hard work and they worked hard all week. There wasn't unanimity at every moment. In fact, there was such a vocal minority that Mrs. Porter, presiding, had to remind the delegates that the majority also had rights. Just before ten o'clock at its first meeting on the evening of June 16 the delegates voted approval of the general plans for the proposed two-organization structure—thus making such approval unanimous for the ANA, NOPHN, and NLNE memberships.

At this meeting also the Mary Mahoney medal was awarded to Marguerette Creth Jackson for her contributions in the area of intergroup relations. Mrs. Jackson is an assistant supervisor, Visiting Nurse Service of New York. The award was presented by Mrs. Mabel K. Staupers, president of the recently dissolved NACGN. This organization established the award in 1936 in honor of Miss Mary Mahoney, the first Negro woman to graduate from a school of nursing, the New England Hospital for Women and Children, in 1879. Hereafter the ANA will sponsor the award.

The last NOPHN rally dinner proved a delightful evening for all—that is, for the nine hundred who could get tickets. The one off-key note was that nine thousand wanted to attend! Sophie Nelson was a marvelous toastmistress. Like so many other wonder workers she must have put hours of preparation into her presentation. She had put together in a beautiful volume (which she presented to the NOPHN) the history of the NOPHN, and she proceeded, to the delight of the audience, to "review the book" as a Sunday supplement reviewer might. She dipped into the foreword and quickly summarized the story of the founding of NOPHN, paying tribute to Lillian D. Wald, Edna Foley, Anna Kerr, Jane A. Delano, Mary Beard, Ella Phillips Crandall, and Mary S. Gardner, and then she introduced Miss Gardner, honorary president of the NOPHN.

Miss Gardner said, "It is a wonderful thing to be at the beginning of a thing and go on and on. I am certain that if that little group [of founders] were here they would think this [reorganization] is the most important step in the history of the NOPHN. The thing to remember is that the early group really had in view something of this sort. It seems incredible that they had such far vision. The opportunity that the public health nurse is accustomed to looking for, finding, and following, is the strength of the organization and will add to the strength of the future."

Miss Nelson then returned to the NOPHN story. She recalled the decision made at the historic meeting in Chicago in June 1912 that since the new organization [NOPHN] would be dedicated to the cause of public health nursing it was important to include in its membership not only nurses but also non-nurses—a very revolutionary departure from the conservative thinking of that time. (And how we all throughout the years have rejoiced in this decision!) Miss Nelson read the list of distinguished NOPHN presidents—the first,

Lillian D. Wald, and after her thirteen others: Mary S. Gardner, Mary Beard, Katharine Tucker, Edna L. Foley, Elizabeth Fox, Mrs. Anne H. Hansen, Sophie C. Nelson, Amelia Grant, Grace Ross, Marian Howell, Marion W. Sheahan, Ruth W. Hubbard, and Emilie G. Sargent. There were eight general directors—Ella P. Crandall, Florence Patterson, Anne Stevens, Jane Allen, Katharine Tucker, Dorothy Deming, Ruth Houlton, and Anna Fillmore; and four acting directors—Theresa Kraker, Mary A. Brownell, Beatrice Short, and Alma C. Haupt.

Miss Nelson paid tribute to the NOPHN staff, past and present. She said they were the expediters of the program.

The *Visiting Nurse Quarterly* published by the Cleveland Visiting Nurse Association was given by that agency as a christening gift to the NOPHN in 1912. Later it became the *Public Health Nurse* and still later *Public Health Nursing*. The editors from the beginning of the *Quarterly* days were Mrs. John H. Lowman, Annie M. Brainard, Ada M. Carr, Dorothy Deming, Purcell Peck, Mrs. Mary E. Shaw, and Hedwig Cohen.

The councils, sections, committees, the SOPHNS, and all their members—all received salutes. Miss Nelson drew to a close by glancing at the "index." Here she paused at the *Bs* because she found so many references to Frances Payne Bolton. In this manner Miss Nelson led up to her introduction of the speaker of the evening, Mrs. Bolton, ever a friend of NOPHN and of nursing. (Mrs. Bolton's address was published in the July issue.)

Finally the rally meeting ended with a dramatic sketch set in the waitingroom of the Interorganizational Lying-In Hospital, June 19, 1952. This was performed by the Convention Players who were assisted by several NOPHN members who had walk-on parts.

There were other meal functions, too. In fact, as one met people hurrying to 7 a.m. breakfasts, rushing to reunion lunches, and trying to decide which university dinner to go to, it sometimes seemed there were too

At the NOPHN Rally Dinner: Emilie G. Sargent, the Honorable Frances Payne Bolton, Mary S. Gardner, and Sophie C. Nelson.

many. But we really would not have wanted to do without a single one of them. And there were especially good program meetings too.

THE NLNE had two excellent lunches. At one Stella Goostray and Pearl McIver presented fine papers which you may have already seen in the *American Journal of Nursing* for July. At the second luncheon Margaret Bridgman spoke inspiringly on potentials in nursing education. She suggested that all institutions of higher learning make some contribution to nursing education—colleges could offer nursing programs in their junior divisions as well as helping nursing schools in the instruction of science courses. Miss Bridgman was introduced by Mrs. Lucile Petry Leone, assistant surgeon general, USPHS, who said the "two-pronged approach in the new NLN combines the promotion of nursing services and education in one organization. This will mean more realistic education and more understanding service."

The NOPHN Board and Committee Members Section, Nurse Midwifery Section, and School Nursing Section held meetings attended by capacity audiences. Papers presented at these sessions will be published in PUBLIC HEALTH NURSING in the next few months. The fourth NOPHN section, the Collegiate Council on Public Health Nursing Education, held a business meeting.

At a joint NOPHN-NLNE program meeting a sociodrama was presented. Apparently every nurse is interested in the question "Who *does* teach the patient" as the huge ballroom was crowded to the rafters. The sociodrama scenes were placed in a hospital and in a home and emphasized the need for and the value of continuity of care. Frances Frazier, instructor in nursing education, Teachers College, Columbia University, was moderator. After the sociodrama a panel of nurses took over and discussed the implications of the various scenes of the sociodrama and the difficulties often encountered in giving "good" nursing service. The moderator for the panel was Vera S. Fry, chairman, Department of Nurse Education, New York University. From conversations overheard in the audience, it appears that this was a first exposure for many nurses to the sociodrama technic and that they liked it.

The convention was honored by the visit of Mr. Benjamin Cohen, assistant secretary general, Department of Public Information of the United Nations, who addressed a joint session. He spoke on the nurse's role in the international scene.

JUST A FEW more highlights from a convention that was a series of highlights! The ANA House of Delegates approved with only a few opposing votes a resolution which stated that the delegates "authorize the Board of Directors of the American Nurses' Association to approve legislation if introduced into Congress during a national emergency which would enact a selective service for nurses." This virtually gives support to a draft of nurses if required during a national emergency.

Three new ANA sections were organized under the revised ANA bylaws—public health nurses; educational administrators, consultants and teachers; and special groups. The latter section comprises all nurses whose operational fields fall into categories not covered by other existing sections. At the first organizing meeting of the Public Health Nurses' Section an overflow audience crowded the corridors of the Ritz-Carlton Hotel. The second meeting was transferred to the arena of Convention Hall, and even that seemed filled up. The public health nurses, needless to say, were vocal and got well under way with their business. They elected as section chairman Mrs. Fannie Warncke, director of public health nursing, Department of Health, Oakland, California. The other officers are Mildred Garrett, director, Division of Public Health Nursing, Texas State Department of Health, first vice-president; Mrs. Pearl P. Coulter, director of public health nursing, University of Colorado School of Nursing, second vice-president; and Mrs. Esther Henry Benjamin, instructor in public health nursing, Wayne University College of Nursing, secretary.

One of the objectives of the ANA Public Health Nurses' Section is "to promote the

standards of public health nursing practice." The members of the section are responsible for defining functions, standards, and qualifications for individual practice in the area of public health nursing.

A group of school nurses requested that a conference group be set up within the Public Health Nurses' Section. The Executive Committee of the section met during the convention and granted this request. At the organizing meeting for the School Nurses' Conference seventy-nine nurses were present. They chose Emily S. Brown of Elizabeth, New Jersey, to be their chairman.

ANA election results were reported the last day of the convention. Mrs. Elizabeth K. Porter, Ohio, was reelected as president. The other officers are Mrs. Lillian Patterson, Washington, first vice-president; Mabel Montgomery, Virginia, second vice-president; Agnes Ohlson, Connecticut, secretary; and Annabelle Petersen, District of Columbia, treasurer.

THE NLN BOARD met from 9 a.m. to 5 p.m. on June 21 and considered the immediate situations requiring decisions in order to continue the active programs of the merging groups—ACSN, NLNE, and NOPHN, and to initiate new activities. Members of four standing committees were appointed—the Executive Committee, Committee on Constitution and Bylaws, Finance Committee, and Membership Committee—and a special committee set up to work out details for the NLN magazine to come out in January 1953. This magazine will be an entirely new publication in which PUBLIC HEALTH NURSING will be included.

The board authorized the formation of councils of agency members in the Department of Baccalaureate and Higher Degree Programs (Division of Nursing Education) and in the Department of Public Health Nursing Services (Division of Nursing Services) as both have charter agency members transferred from NOPHN and ACSN, respectively.

Steering committees for the two departments mentioned above and for the Department of Diploma and Associate Degree Programs will shortly be elected by mail vote by the members of each department. The steering committee for the Department of Hospital Nursing Services was appointed by the board from a fixed slate, as this department had no members transferred to it.

An interdivisional council on psychiatric nursing was established upon petition of more than six hundred members.

The board set up an interdivisional committee on practical nurses and gave it the responsibility of studying the question of practical nurse membership in the NLN—a request made by members at the first NLN meeting. Other interdivisional committees established by the board are the Committee on Poliomyelitis and Orthopedic Nursing (formerly Council on Orthopedic Nursing—JONAS) and the Committee on Tuberculosis Nursing (formerly Council on Tuberculosis Nursing—JTNAS).

Still other committees authorized by the board are a committee to study how needs of organized industrial nursing services and industrial nursing education can best be met in the NLN; an advisory committee to the Division of Nursing Services, made up of members of the former NCINS; Committee on Careers in Nursing, which is to become an interim committee, Division of Nursing Education; and an interdivisional committee on nonnurse participation. Formation of the latter committee was requested by the Executive Committee of the NOPHN Board and Committee Members Section. The board decided to hold in abeyance the provisions in the bylaws which refer to a student council and student membership, et cetera, as the more than one thousand students who attended the convention had decided to set up one separately organized national council of student nurses to function under the coordinating council of the ANA and the NLN.

OTHER THOUGHTS come crowding thick and fast. The exhibits were just wonderful and all the exhibitors deserve our gratitude for their informative and attractive displays. All the booths drew large crowds. This was equally true of the commercial and of the professional exhibits. At the NOPHN booth we had a beautiful guestbook but the stream of visitors wiped all thoughts out of our minds of asking people to sign. So we don't have a

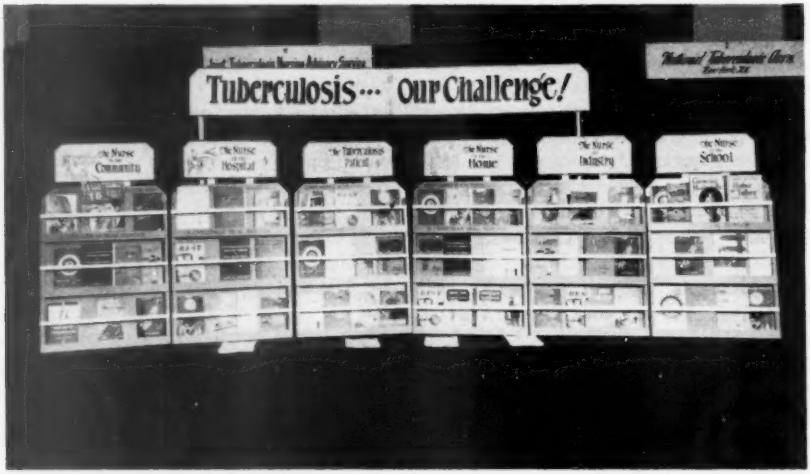
signature, but we do have the memory of short visits with thousands of members and other friends who stopped by.

The general members had their hospitality booth at one side of the NOPHN display and on the other side was a special NOPHN display of records which turned out to be very popular. The people who staffed the records booth have two overall impressions: The field of public health nursing is cost conscious and everyone asking about nursing records was interested in the generalized family record to the exclusion of all other types. There was also a great deal of interest in mechanical aids which might shorten time spent in tabulation of data.

Below is a picture of the JTNAS booth. This was designed by Thomas Summers, director of health education, Kentucky Tuberculosis Association, originally for a work conference in tuberculosis nursing in Kentucky. The display was lent to the NTA and JTNAS. JONAS had a pictograph display, "Orthopedic principles belong to all nursing." Both exhibits drew many visitors. Student nurses in particular were interested and stopped to ask many questions.

In a convention that will be noted for many "firsts" here is another first to report. A semi-documentary film of the outstanding events of the history-making convention was made by Wyeth, Incorporated. Wyeth expects to have the film available for professional nursing meetings by September. Write to Film Library, Wyeth, Inc., 1401 Walnut Street, Philadelphia 2, Pennsylvania, and ask for Teleclinic Highlights of the 1952 Biennial Nursing Convention.

Probably because it was such a wonderful convention it's difficult to wind this account up and write finis. Fortunately, every one of the more than nine thousand who attended the convention will think of something special to report, so that eventually the whole story will be told. Of this we can be sure: We came together in good spirit; we early reached an accord of mind; and we left happy in our achievements.



The Tuberculosis Advisory Nursing Booth at the Convention

Tips on Using Educational Films

JAMES C. GEIGER

TODAY EVERYONE knows audiovisual aids play an important part in the success or lack of success of a health education program. There is a growing wealth of films, especially valuable for an effective well rounded teaching program, but it is surprising how few health workers feel at ease in using films.

Any educational motion picture is primarily a teaching tool or a supplement to other materials and therefore the way it is presented is important. The audience must be prepared in advance for what it is to see. This means that the worker responsible for the meeting must be familiar with the content of the film and able to explain briefly and interestingly why it is being shown, indicating points that should be specially noticed. Don't tell the story. A person experienced in using films for educational purposes knows also the value of prepared questions to open up the discussion at the end of the showing.

Let's go back to the mechanics: Of course, it is not enough simply to know how to thread a machine and project the film on the screen—although this is the first thing we must learn. A competent instructor can teach the operation of the motion picture projector in less than an hour. It is wise to learn from someone who really has the know-how. Two or three hours of practice should enable a nurse to carry on alone without difficulty. Confidence comes with experience. There are a number of different makes of projectors. Each differs a little in how it's threaded and operated, but once an individual understands the general principle it takes a short time to catch on to the operation of a new type of machine.

As in every other art and craft there is a technical language and it is helpful as well as satisfying to be familiar with the special terminology. It adds to the feeling of being at home in the field.

Projection lamp. Large lamp (up to 1,000 watts) usually located directly behind the aperture plate. In large auditoriums 1,000 watt bulbs are required.

Exciter lamp. Small lamp located near sound drum. This lamp picks up the sound impulse from the film. If the exciter lamp does not burn there will be no sound.

Speaker cable jack. The plug on the end of the wire from the speaker.

Focusing lens. Round lens, from one to two inches in diameter and approximately three inches long, located directly in front of aperture plate; used to obtain clear, sharp image on screen.

Fuse. Small electrical fuse about one inch long and one-sixteenth inch in diameter. Fuses are located at various places on the machine, according to the make.

If you are responsible for showing slides or a movie at a meeting it is a good idea to get to the room at least half an hour before the program is to begin, even if the film is not scheduled until late in the program. This will eliminate having to mill around among the crowd to set up the equipment and getting into a "state" about it. It's ideal to have a husky man around to help move equipment, et cetera, but generally someone will lend a hand in loading and unloading.

Always make a last-minute check of the equipment before starting out from your home office. Be sure that you have all the necessary accessories for putting on a good show and for coping with any emergencies that may arise. These accessories include the screen, extra projection lamp, extra exciter lamp, brush for cleaning aperture plate, lens cleaner, lens tissue, heavy extension power cable, and

Mr. Geiger is film librarian, Florida State Board of Health.

a 1600-foot take-up reel. (Oh yes, and don't forget the film! This disaster sometimes occurs.)

UPON ENTERING the room where the film is to be shown a check of the following items should be made: seating arrangement (if seats are not stationary) lighting, light switches, and proximity of electrical outlets to projector. As we all know, the darker the room the better, whether slides or motion pictures are being used. If it is a daytime program and the windows are not equipped with dark shades or drapes and if the seats are movable, arrange the seating in a manner that will permit the screen to be placed in the darkest part of the room. Special daylight screens are available for rooms that cannot be darkened. Whenever possible have the first row of seats at least fifteen to twenty feet away from the screen. When sound films are being shown place the speaker near the screen. The speaker should be elevated three or four feet. If a standard 16mm projector is being used place the projector about thirty feet from the screen, or at a sufficient distance to fill a 52x70-inch screen. (The farther from the screen the projector is, the larger the image will be.) String the power and speaker cables along the wall of the room, or away from the pathway of the audience as much as possible.

When setting up a projector the use of a projection stand is advisable. However, if a stand is not available always make certain that the table used is sturdy enough to support the machine. In order to project over the heads of the audience the projector should be at least four feet from the floor. To project lower than this necessitates having a center aisle in the seating arrangement in order that the beam of light from the projector will not fall on persons seated in the audience.

The secret of good picture projection lies in the use of clean, well maintained equipment. When the projector has been placed on the stand or table, and before the film has been threaded, turn the machine on and center the light beam squarely on the screen. If you are not projecting a sufficient distance for the light image to fill the screen then make certain that the border around the edge of the screen is even on all sides. If "fuzz" appears around the edges of the light image it means that the aperture plate is dirty. This can be cleaned by removing the focusing lens and using the small round brush in the accessory kit. On some makes of projectors the aperture plate can be removed for easy cleaning. When this is finished the focusing lens should be cleaned using the lens tissue and cleaner from the accessory kit.

After this has been done the amplifier should be turned on and allowed to warm up. To test the amplifier to determine if the sound is working properly turn the volume control switch all the way on. If a hum is heard through the speaker then in all probability the amplifier is in good working order. On some machines it is necessary to turn on the motor before the hum can be heard. If no hum can be heard through the speaker after about thirty seconds you are not getting any sound and a check should be made to determine the cause. First check to see if the speaker cable jacks are securely in place on both the projector and the speaker. Inspect the speaker cable to determine if any wires are broken. Check the exciter lamp. Is it burning? Check the fuse to see if it is burned out. Lack of sound can usually be traced to one of these things. If, after a thorough check, there is still no hum through the speaker it means that the amplifier itself is not in working order.

After determining that the sound is working you are ready to thread the film onto the projector. Follow directions on the chart which is usually available with the projector. The directions may be in a manual or pasted inside the projector door. Make certain you have the correct size upper and lower loops. The lower loop is especially important. If it isn't the correct size the sound will not be synchronized with the lip movements of the characters on the screen. Be sure to test the threading with the manually operated knob (which most projectors have) before turning on the motor. When the film is properly threaded turn on the projector and run off about thirty feet of film in order to adjust the focusing lens and the volume control. On most makes of projectors the film can be reversed while still threaded by flipping a

key marked reverse. If you can't do this, after running off the thirty feet of film, loosen the film, rewind it, and thread the machine again.

When you have threaded or reversed the film make certain that all the leader film has been run beyond the aperture plate and that the title frame of the picture will appear on the screen when the projector is turned on. It is a good plan to have a member of the audience stand by ready to turn off the lights when you are ready to start the projector. Remember, never leave the projector while the film is being run off. Even though a film has been thoroughly inspected a splice will come apart occasionally. When this happens the projector should be turned off immediately. It will then be necessary to thread the machine again, leaving two or three feet of loose film in order to engage the torn film onto the take-up reel.

IF THE picture suddenly begins to flicker on the screen it usually means that the film at that point has torn or strained sprocket holes. On some makes of projectors there is a small lever that can be flicked up and down and if the torn part of the film is not too large this action will correct it and the film will run smoothly again. If, after manipulating the lever, the film still flickers on the screen turn the projector off immediately. It will then be necessary to thread around the torn spot and continue from there. Don't be guilty of crossing your fingers when something goes wrong, hoping that the trouble will correct itself. It won't. Actually what is happening is that you are tearing more and more film as it feeds through the projector. It is better to risk the embarrassment of stopping the show and threading again than to inflict heavy damage to the film. Films are expensive!

If more than one film is being used make certain when rewinding that each film is placed in the proper container. At the conclusion of the program fill out the exhibitor's report card that accompanies the film.

There are educational films available on practically every subject of interest. It helps, of course, to be familiar with several sources. Practically every state health department has its own film library; some have beginners' collections and some states have more than a thousand prints. Usually the state health department can also refer you to a specific distributor if it does not have a particular title or a film on the subject matter you are interested in. Other good sources to investigate are state university extension services, state departments of education, national, state, and local voluntary health organizations, companies such as the Metropolitan Life Insurance Company, National Dairy Council, et cetera. Many films are available free of charge except for postage costs; others may be rented for a few dollars—and all of them are usually in demand, which means that requests must be sent in early. Many film libraries will not fill a request unless it is received one or two weeks in advance of the showing date. Allow time to preview the film if you are not already familiar with its contents; and an especially good rule is not to build a program around the use of a film until confirmation of the booking is received from the film library or other source from which it is to come.

If you are going to show films (or film slides) you'll be happier and will give a smoother performance if you set out to acquire skill in this. If you're going to work with someone else—possibly a projectionist—it's helpful to know what he's doing also. All health workers should be able to use audio-visual equipment without undue wear and tear on the nervous system.

* * *

Here are notes about a few of the newer films you may be interested in using.

Welton, A Healthy Community. The film shows how a community can maintain high standards of public health on a low budget. An interesting feature is the portrayal of active cooperation among various community agencies through the working together of the health officer, public health nurse, teacher, food handler, and consumer. This film is good for lay and professional audiences. Running time 31 minutes, 16mm, in color. Rent from Instructional Materials Center, 401 Administration Building, University of Washington, Seattle 5, Washington. Charge, $3.25.

Breakdown. The story of a young woman's schizophrenic breakdown and of her recovery in a modern hospital. Implicit in the film is an appeal for greater public understanding of mental illness.

Daily routines and treatment in the hospital are shown. Running time 41 minutes, both 16mm and 35mm, black and white. Write to the distributor, McGraw-Hill Text-Film Department, 330 West 42 Street, New York 36, for rental sources.

Fears of Children. A film about a normal five-year-old and his well intentioned parents. In a series of episodes typical of those arising in families with small children it shows how Paul's fears are related to his feelings about his parents. The parents reach a new understanding about child behavior, and although the boy's problems are not all solved his mother and father have begun to develop attitudes which in time will be helpful to the child. Running time 27 minutes, 16mm, black and white. Information about rentals from Mental Health Film Board, 164 East 38 Street, New York 16. Charge, $5.

A Concept of Maternal and Neonatal Care. The film shows what may be ideal care but should be of value in any situation where high standards are being sought. Good portrayal of the new hospital unit setup for rooming-in. Staff of any hospital considering introduction of rooming-in will find this film helpful. Running time 26 minutes, 16mm, black and white. Rent from Medical Film Institute Services, 13 East 37 Street, New York 16. Charge, $5.

1952 Biennial Film Program

WERE YOU AT the convention, and did you attend any of the film programs? More than 4,500 persons did. During four days, eighteen films were shown, each one followed by comments by experts and discussion from the floor. Mental health films drew especially active audience participation. Lily C. Hagerman, USPHS, and Gertrude Stokes, University of Rochester, had audience commentators lining up at the microphone. A high note was struck also by Mary Forbes of the Division of International Health, USPHS, who followed presentation of a mutual security program film on furthering public health in Greece by a personal report of her own experience with the American nursing mission in Greece and an account of the latest developments.

Other commentators included Verda Hickcox, head of obstetric and gynecologic nursing service, Cornell University-New York Hospital; Frances Frazier, instructor in nursing education, Teachers College, Columbia University; Dorothy Mereness, assistant professor of psychiatric nursing, University of Pittsburgh; Mrs. Sara Wright Kelley, public relations consultant, Committee on Careers in Nursing; M. Ruth Moubray, executive secretary and counselor, Maryland SNA; Berdine Thompson, associate executive secretary, Minnesota Professional Counseling and Placement Service; A. June Bricker, director, Home Economics Bureau, Metropolitan Life Insurance Company; Katherine C. Neill, director of nursing, Department of Public Safety, Rochester, New York; Jean South, public health nurse consultant, JTNAS.

The commentators, however brief their remarks, gave forum quality to the program and related the films to current problems. Film subjects included general health, mental health, public relations, counseling, nursing recruitment, social problems, the international scene.

The program was planned by the 1952 Biennial Film Committee, Elizabeth C. Stobo, assistant director, NOPHN, chairman. Other members were Frances Tompkins, assistant to the director, NLNE; Mrs. Evelyn Baker Ferguson, assistant executive secretary, ANA; and Kathryn Linden, ANA audiovisual consultant, and chairman, ANA Committee on Films. Miss Stobo opened the film program, emphasizing the forum quality of the film showings, and Miss Linden introduced the speakers and kept the program moving along.

The members of the film committee hope you will send them your opinions and suggestions, if you were present at any of the film showings. The committee would like to know whether you prefer introductory talks on the films, whether you like the plan of following the film presentation by comment and discussion, whether you prefer fewer film showings with more discussion. Your answers will help the committee in future planning.

Maternal and Infant Care Customs Among Hawaiians Today

The author reports impressions gained from interviews with ten Hawaiians of various backgrounds about the extent to which certain customs prevail and influence the reaction of presentday Hawaiians to childbirth.

ALISON MacBRIDE, R.N.

MANY OF THE customs of old Hawaii concerning childbirth and infant care stand up well in the light of modern knowledge of what constitutes good maternity care. However, it is evident that much has been forgotten and that only a few taboos and practices of Old Polynesia guide the mother and child of today.

Although many of the protective elements in the old culture have been forgotten the Hawaiian family has not embraced modern hospital and medical care as an acceptable substitute. Public health statistics indicate that Hawaiians do not choose to take advantage of modern methods. The Hawaiian mother prefers to have her delivery at home, assisted by her family and friends rather than by a physician or midwife. And Hawaiian babies have a much higher mortality rate during the first year of life than do infants of other racial origins in the Territory. Incidentally, people of Hawaiian ancestry constitute about 2.8 percent of the population of the Territory and in 1949 only 166 Hawaiian infants were born.

The sociologist reminds us that cultural transition is a slow and gradual process, more particularly with an independent and intelligent people like the Hawaiians. They continue to live in the environmental matrix of their heritage out of which custom evolved. Quite different is the case of the people of other racial origins in Hawaii, who voluntarily transplanted themselves. Because of that they have been more ready to abandon their cultural ways and substitute elements of the new culture they came to live within.

In order to ascertain to what extent the old practices relating to childbirth and the care of the infant prevailed opinions were sought from ten Hawaiians of varying backgrounds. The size of the opinion sample does not justify generalizations. Cursory impressions gained by the interviewer about some of the forces which are influencing our modern Hawaiians as they solve some of their problems during the maternity cycle are presented below.

The ancient Hawaiian theory of nature regarded all phenomena as psychophysical. Deepseated illness and abnormalities were ascribed to psychic conditions and causes. These malevolent influences often came from outside the sufferer and might be the result of concentrated spite, hate, or jealousy in the heart of another which worked telepathically against the victim; or the condition might be the result of possession by a ghostly demon spirit which had escaped from its keeper. Pregnancy was considered to be vulnerable to such psychic genera, particularly jealousy. Consequently, the fact of pregnancy was a carefully guarded secret.

There are several indications that these theories still prevail, with all the implications possible for mother and child. Pregnancy is not spoken of freely and then only within the bosom of the family for fear of another's

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jealousy. A woman must be careful not to eat a food which in the form of a bird, fish, or animal represents her guardian spirit or angel, lest protection be withdrawn. Ti leaves, worn next to the skin, are believed to ward off evil. It is common practice for Hawaiian friends and relatives to gather for prayer to release a woman who has complications at childbirth. Screaming is regarded as a sign of possession. Excessive labor pains, which may be due to an evil cause from without, will be transferred by these prayers to a proxy—another woman who is glad to help her laboring sister.

In keeping with this psychic theory the vestigial remains of an ancient purification ceremony are sometimes practiced. This ritual drives out any lingering malevolent influence from the mother just before the infant is born. An elder assuming the functions of the ancient kahunas (priests, teachers, physicians) presides and receives the woman's confession; then a suckling pig or garden-variety chicken is sacrificed.

Another related custom is the careful observance of the ancient taboo on sewing or knitting or lei wearing during pregnancy, lest the infant be strangled by the umbilical cord.

IN OLD HAWAII the mother's diet was strictly regulated from the fourth month on; hot spicy foods were not allowed or too many salty foods. Greens of various kinds (popolo, luau, et cetera) and mild medicinal herbs were advocated to build up the child's body. These greens were high in vitamins, iron, and calcium and are recognized nutritional requirements for health today. Unfortunately, these sound dietary principles have been largely lost. Some Hawaiians add seaweed to the diet in extra amounts in the last trimester, and the taboo on spicy foods is observed, which is a sensible way to avoid digestive discomfort. The Hawaiian diet today leaves much to be desired from the standpoint of nutrition during pregnancy. Little fruit, vegetables, and milk are taken, and since rice is supplanting poi to an undesirable extent the diet is often deficient in calcium as well as in vitamins A and C. The modern Hawaiian mother lacks the protection which the ancient dietary taboos provided in pregnancy.

On the lighter side, some of the most delightful imagery is contained in the ancient folklore surrounding food cravings. It is believed that the disposition, health, and behavior of the child were determined in utero and could be predicted by these cravings: if the mother craved a pilii (bivalve which clings to a rock) the child would have a very affectionate nature and only death itself would part him from loved ones; if she craved a manini (fish which hides in recesses of coral reef) he would be shy; if luau (taro tops) he'd answer questions only by nodding his head like the swaying of the taro leaf. Sex could be determined by asking the mother for her hand, which if extended palm up meant the child would be a girl and if palm down the child would be a boy.

Modern science still has no light to throw on the reasons for capriciousness in food habits during pregnancy and the modern Hawaiian does not subscribe to the theory that these cravings predict personality characteristics. One story was elicited in support of this

ancient folklore: Only after one mother observed her wriggling son did she remember she had craved a sea urchin early in pregnancy! However, the pregnant woman is still likely to have an oldtimer ask her for her hand and tell her the sex of her child.

The ancient concept that parental behavior during pregnancy would affect the nature of the child finds corroboration in modern epidemiologic concepts in the field of mental hygiene. Ancient and modern Hawaiians believe that if parents are lazy their offspring will be lazy and poor providers, so the Hawaiian mother is apt to be busier than usual during pregnancy. The family behavior pattern is recognized today as basic to personality development.

The oldtime kahuna used postural exercises and lomi-lomi (massage) to make delivery easier. The expectant mother still employs the massage skills of her mother, or a relative expert in lomi-lomi, in the last trimester to reach the same goal—strong muscles to facilitate delivery. The grandmother-masseuse is continually observant of the infant's position and manipulates the abdomen manually to assure a vertex presentation. It is interesting to note the recent emphasis in obstetrical practice to include exercises and relaxation regimes as part of antepartal care.

Many relatives gather for the birth of the child. The mother is encouraged to walk to and fro, and when the pains become more intense she takes a kneeling position with her knees apart. A relative places his knees in her back and when the child is born grasps her around the waist and exerts pressure on the fundus; another relative supports her in front, knee to knee and hand to hand. This squatting position is still preferred by many women. It is the natural position in many cultures, and the common practice of insisting that a woman deliver in bed is contrary to primitive, instinctual dictates.*

In the past the mother after her delivery was given a warm broth and herbs to help her fill the empty feeling (hakahaka) and to expel excessive blood. Each kahuna had his own preference about herbs. Today various herbs crushed in water are given. The one most frequently mentioned is ashes of guava stumps. When tearing has occurred a pad saturated with olena (ginger) alae (red dirt) salt, and water seems to have remarkable healing effects. The Hawaiian believes it is bad to wet the umbilical stump and keeps it dry, using pia (starch) to correct bleeding.

The old folklore prescribed caution in the disposition of the afterbirth and cord (piko). These are considered to be extensions of the child, who will be affected if they fall into the wrong hands. If a rat eats piko the child will be a chronic thief. The afterbirth was washed well to prevent the child having sore eyes; then it was buried deep, and a tree planted over it which could not be cut down so long as the child lived. Many stories were told in which the afterbirth or miscarriage products were thrown into the ocean and became a family guardian spirit in animal form. Similarly the afterbirth is protected today by deep burial and the place often kept a secret.

In Haleole's romance of *Laiei Kawai* the old grandfather who saved the life of the twin sister wore her umbilical cord around his neck to keep it from harm. On each island there were designated places of safety for the disposal of piko. For example, at Honomolino landing in South Kona there is a rock of legendary interest which appears above the surface at low tide. In the old days anxious parents, seeking the welfare of their offspring, traveled some distance to secrete piko in a hole in this rock, which was then sealed by a smaller stone.

Preservation of piko is still regarded as an important charge upon parents or guardian of the child until it can be disposed of safely. Many a Hawaiian home has these treasures stored in a bottle or metal powder box.

ACCORDING TO the old custom the first son was reared by paternal grandparents and the first daughter was reared by maternal grandparents. If these parents were dead the relative next in seniority line assumed responsibility for these children. The presumptive guardian always was present at and assisted with the birth. Social pressure continues to

* Vaughn, K. *British Medical Journal*, January 31, 1950.

be exerted upon parents to give up firstborn children to grandparents. However, the mothers who were interviewed had been successful in repudiating the claims of grandparents to their offspring.

The Hawaiian baby's first solid food was mashed sweet potato. At six months poi was given and a little later the soft parts of the limpet and vegetables and meat broths were added. By the end of the first year mixed herbs were given, mashed kukui nuts, crab juice, and vegetables. When an infant required medicinal herbs the mother chewed these and mouth-to-mouth feeding was administered.

The modern one-year-old is customarily given a slightly different variety of foods, but the dietary principles are similar. In addition to his mother's milk (or that of a wet nurse) foods rich in minerals, vitamins, and protein are added. Poi is still the most important supplement to milk.

Hawaiian mothers and grandmothers continue the old belief in the value of massaging and stroking the infant's head and extremities, particularly the fingers, to develop a well formed body. Swathing the infant in tight binding cloth to keep back and legs straight was not resorted to as in many European cultures. It is not an uncommon sight to observe Hawaiian mothers stroking their children purposefully, in a manner not observed among other racial groups in the islands.

These are a few of the ancient Hawaiian customs which have been carried along in the stream of consciousness and are influencing to a greater or lesser degree the modern Hawaiian's behavior in childbirth and the care of the infant. Some of these prevailing customs undoubtedly explain the Hawaiian's preference for a home delivery, assisted by friends and family. The poor economic status of most Hawaiian families would almost be a sufficient determining factor in the rejection of modern care and protections, without seeking the cultural factors which seem to be determinants.

Hawaiians did not express any fear of hospitals or medical care, rather an indifference toward them. The modern Hawaiian frequently combines the old therapeutic practice with the modern when she is under the care of a medical doctor.

Another potent force working against modern hospital and medical care in the Hawaiian community is the tales of individuals' unfortunate experiences with professional personnel. These stories are told and retold whenever the question of hospitalization arises. That this force is a particularly potent one cannot be doubted when one remembers that the Hawaiians had no written language, and history and tradition were and are handed down through the spoken word generation to generation through meles and storytelling. This fact of community life provides a chain reaction effect for each hospital experience of a Hawaiian whose pride and sensibilities have been irritated knowingly or unknowingly by an insensitive nurse, doctor, or other hospital personnel.

This paper has also been published in the *Hawaii Medical Journal*, November-December 1951.

The Public Health Assistant In a Health Department Program

JESSIE M. DAWSON, R.N.

THE PROGRAM of the New York City Department of Health covers a variety of services. The public health nurse functions in a generalized family health program. She also is assigned to clinics and conferences conducted by the department.

For many years the department recognized the need for a new type of employee in the clinics. Public health nurses had to spend too much of their time on duties which did not require professional preparation. This was an especially serious handicap as a nursing shortage was the major personnel problem in the Department of Health. To a limited degree the situation was relieved by the use of clerical workers but many tasks remained which were not properly assignable to either nurses or clerks.

A department committee of administrators considered the problem and agreed that a new type of worker was needed, the public health assistant. Her duties and training were discussed and the Civil Service Commission set up the requirements for appointment as follows:

A candidate for the position of public health assistant must have had at least one year full-time paid experience as an assistant in a doctor's office or in a hospital clinic or satisfactory equivalent. Training or experience relevant to the job acquired on military duty or while engaged in veterans training or a rehabilitation program is accepted as a satisfactory equivalent. The applicant must be a citizen of the United States, a resident of New York City for three years prior to filing application, and must pass a written examination and a medical examination.

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Functions of the public health assistant

The public health assistant is assigned by the Bureau of Public Health Nursing, under the supervision of the supervising nurse in the district, to aid in the operation of clinical and other activities of the Department of Health; assist professional employees in the clinic, schools, and other locations in the performance of the nonprofessional phases of their responsibilities; keep clinic rooms in order before, during, and after clinic sessions; replenish supplies, change linens, clean and sterilize instruments and equipment, and set up and clean various types of trays; assist in preparation for and during examination of patients including weighing, measuring height, taking temperature, and escorting and chaperoning patients; keep supply closets in order and prepare supplies as necessary; keep clinic desks supplied with stationery, ink, pens, pencils, and forms; provide for a supply of selected literature on waitingroom tables; act as receptionist giving directions and general information concerning clinical and other facilities; register and meet patients, obtain and record identifying data; make and keep track of patients' appointments; address postcards and letters to patients, physicians, and various agencies; record laboratory and other medical reports in patients' records, transfer records from one clinic to another, and file records; perform related duties as assigned.

Training program

Criteria and objectives for the training program for the public health assistant were set up by the educational staff of the Bureau of

Public Health Nursing. The basic objectives of the program were to help the new worker to understand the Department of Health's role in the community and to help her to develop skill in the jobs she was to perform.

In general a new assistant reports to the training center, located at the Corona Health Center, for one week. After that she is assigned to the district in which she is to work and returns to the training center for one day a week for the following five weeks.

Throughout the course a functional approach is used. Content material is related to the activities she will carry out. There are group discussions, limited practice periods, and reviews. Emphasis is placed on situations where most public health assistants work—child health stations, tuberculosis, social hygiene, antirabic, and eye clinics.

It is obvious that only basic principles of technics, a very limited practice period, and an overview of the department can be given in this short period. Therefore, the public health nurse in charge of the clinic and the assistant supervisor play important parts in the continuing training of the public health assistant.

Problems and assets

One of the biggest problems encountered was that of understanding and acceptance by the professional staff of the functions of this new type of worker. This was most acute in the area of semiprofessional activities, such as the compilation of statistical reports and daily tallies, a responsibility which some public health nurses found hard to relinquish. Another problem concerned an adequate salary differential between the professional personnel and the public health assistant.

The most important benefit realized from the addition of the public health assistant to the service was the freeing of public health nursing time for public health nursing functions. In one district this released time was diverted to additional home visiting and service to children in school. Although it took a few months to achieve there is almost universal acceptance of the public health assistant by the public health nurse and doctor. The requests for such aid can't be filled.

Conclusion

From our experience it can be said that the public health assistant as an auxiliary worker in the nursing service has proved a decided asset in relieving the nursing shortage.

The factors to be considered when taking on such personnel are the effect on the staff—both supervisory and field—the orientation period needed for training, the content of the training course, and the future development of such workers.

As to future development, we can see the public health assistant who shows some administrative ability being given special training to prepare her to take over clinic management. The public health nurse in the clinic setup would then function as a conference nurse. In fact, a beginning toward this end has been made: selected public health assistants are acting as clinic managers in the nutrition clinics.

The Public Health Nurse—Who Is She? What Does She Do?

WHAT DOES the public health nurse do? Whom does she serve? Are her preparation and functions different from those of the nurse in the hospital? In order to find out what a selected group of young adults knows about the public health nurse and her work the authors of this study interviewed 47 couples living in Shanks Village, New York, and asked them to fill out personal data sheets and answer specific questions.

Shanks Village is a low cost housing project for the families of veterans with dependents, a large percentage of whom were attending nearby colleges and universities when the village was set up in 1946. An active Village Residents Association provides many services

TABLE 1. Opinions in Answer to General Questions about the Public Health Nurse

Questions	Opinions			
	Men		Women	
	Yes	No	Yes	No
1. Do you think the public health nurse is a registered nurse?	43	4	44	3
2. Should the public health nurse wear a uniform in performance of her duties?	41	6	43	4
3. Are the services of the public health nurse mostly for the needy?	22	25	26	21
4. Is the school nurse a "truant officer"?	45	2	44	3
5. Should the school nurse transport sick children home?	30	17	34	13
6. Should physical examinations of children in school be given at yearly intervals? If not, how often would you suggest?	30	17	32	15
7. Do any public health nurses charge a fee for their services?	6	41	14	33
8. If you saw a public health nurse visiting a neighbor would you think the neighbor could not afford to have a private nurse?	9	38	14	33
9. Does the public health nurse ask too many "personal" questions?	3	44	1	46
10. Are the education of the practical nurse and that of the public health nurse almost the same?	15	32	4	43

for the promotion of the health and welfare of the tenants. A nurse from the county public health nursing service has office hours at the health center in the village and works closely with the health committee.

The men and women who participated in the study were between the ages of twenty to forty; 75 percent of the men were in the twenty-five- to thirty-four-year age group and most of the women in the twenty- to twenty-nine-year age group. Most of the men and more than half of the women had attended college; only one man and two women were not high school graduates. Thirty-six of the men and 22 women had at some time been in a hospital; 14 men and 18 women had had contacts with a public health nurse.

Table 1 reports the general opinions of the group. The authors discuss the opinions and arrive at conclusions. Following are selections from this section of the report:

Some of the misconceptions regarding the background of the public health nurse seem to be disappearing. Apparently public health nursing is still identified as a service for the lower economic groups. About two fifths of the answers indicate a belief that the public health nurse does not charge fees. This may reflect the fact that most of the group's contacts have been with official agencies. A large part of the group—men and women—think the public health nurse should wear a uniform. Does the uniform add to the patient's sense of security when he does not know the nurse?

About two thirds of both the men and women indicated their approval of annual physical examinations in school. The others reported that examinations should be made more frequently. Is this an indication of a changing philosophy, that public agencies should assume responsibility for the health of the individual? Or could this be a conditioned response on the part of these parents, a result of their frequent visits to the pediatrician with their preschool children?

Table 2 gives the group's answers to questions about specific public health nursing responsibilities.

Following are some of the authors' comments on the responses to specific questions of nursing activities:

As was expected the highest correct scores were in the areas of instruction regarding the care of new babies, advice to pregnant women, and care of the sick at home. These are the traditional areas of public health nursing and are the services which have had greatest publicity. The men showed less familiarity than their wives with parents' classes. Why haven't the mothers talked with their husbands about

TABLE 2. Opinions about Statements of Specific Public Health Nursing Responsibilities

Statements	Opinions					
	Men			Women		
	True	False	No Opinion	True	False	No Opinion
1. The public health nurse gives instructions regarding the care of new babies.	43	0	4	44	1	2
2. The public health nurse gives advice to pregnant women.	42	1	4	36	1	10
3. The public health nurse conducts mothers' classes for pregnant women.	29	15	3	44	0	3
4. The public health nurse conducts fathers' classes for expectant fathers.	13	11	23	24	10	13
5. The public health nurse assists the family in planning a budget.	7	22	18	10	21	16
6. The public health nurse gives care to people sick with contagious disease.	34	5	8	33	4	10
7. The public health nurse gives care to any sick person and instructions to members of the family to care for the sick person in her absence.	44	0	3	44	0	3
8. The public health nurse does health teaching in all the families visited.	23	11	13	32	6	9
9. The public health nurse gives care to all age groups from infancy to old age.	42	1	4	43	1	3
10. The patients of the public health nurse represent all colors, creeds, nationalities, and economic statuses.	38	5	4	38	5	4
11. The public health nurse visits only in homes where there are health problems.	16	25	6	15	22	10
12. The educational backgrounds of the patients of the public health nurse range widely, some have never been to school and some are college graduates.	31	12	4	36	6	5
13. The public health nurse works only under the direction of a doctor.	8	31	8	6	31	10
14. The public health nurse has no concern with behavior problems of children.	6	27	14	6	27	14
15. The public health nurse is concerned only with the sick.	7	36	4	18	18	11
16. The public health nurse is not equipped to advise on problems other than those dealing with sickness.	6	32	9	9	28	10
17. The public health nurse assists parents in understanding and handling such problems as thumbsucking, temper tantrums.	34	5	8	33	2	12
18. The public health nurse changes dressings in the home on wounds, burns, and following operations.	37	1	9	38	1	8
19. If the public health nurse sees the patient in clinic there may be need for her to make a home visit.	5	27	15	7	28	12
20. Bedside care of the sick at home is an important duty of the public health nurse.	26	17	4	29	10	8

the classes?

The study indicates many areas of confusion and the continuing need for education of the public about the public health nurse and public health nursing.

Report of a study carried out by Kathleen Lepper, R.N., and Thelma Coyne, R.N., in the course Foundations of Nursing Education (advanced) at Teachers College, Columbia University, in 1951.

Our Stake in the Future

ELEANOR HAWLEY, R.N.

"NURSE, DO YOU have any all day suckers heah?" The little boy, four years of age, tugged at the public health nurse's apron and looked up hopefully. The nurse smiled, stooped down to the child's level as she answered him, and said: "Why no, Jonathan, I'm afraid we don't have all day suckers. Did you get suckers at the well child conference when you lived in Dallas?"

"No'm, not at the conference," said he, shaking his head, "but I did at the doctor's office when the nurse sent me when I wuz sick."

"But are you sick today?"

"No'm, I ain't sick no more."

"Then come on over here and let's see what we can find to play with."

The nurse arose, took the child's hand and led him over to the play corner where several children of assorted ages were playing with blocks, spoons, box nests, balls, bean bags, and similar toys. Jonathan found a toy which interested him and he was soon an active part of the busy little group.

This is a fairly typical picture of activity in a well child conference before the physician arrives to examine the children. An attempt is made to maintain a cheerful environment, which is usually a noisy one as well. Happy children are seldom quiet for very long periods of time.

Well child conferences are not new to Texas. They have developed over a period of thirty years from an occasional inspection offered children as a May Day program to an established service of 190 conferences serving more than 80,000 children within the age range of infancy to six years.

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The objectives of this program in the field of preventive medicine are twofold: to promote and maintain the optimum health of our children through disease prevention and to educate parents to be aware of and to meet the fundamental needs of the child.

The staff which serves in the conference—namely, a physician, one or more public health nurses, and one or more volunteers or nurses aides—has additional aims which we may list as follows:

1. To observe closely the physical growth and development of the individual child.
2. To guide parents in providing an adequate, well balanced diet suited to each child's needs.
3. To recognize tendencies, both physical and mental, which deviate from the normal.
4. To recognize early abnormal emotional tendencies so that faulty behavior patterns may be avoided.
5. To prevent certain specific diseases through dietary supervision and immunizations.
6. To teach health principles and health habits to parent and child.
7. To educate parents through anticipatory guidance to be prepared to recognize and fulfill in so far as possible the essential needs of their children.

These aims and objectives review in brief the purpose of a well child conference in our state. You have noticed that mention of treatment of disease and care of sick children is omitted. The omission is intentional, for the underlying philosophy of the conference is to educate parents to recognize the need for continuous medical supervision for their children by the private physician. Children who report to the well child conference and who show signs and symptoms of illness are immediately excluded and are referred to the

family physician, a pediatric clinic, or similar community sources for care.

THE ORGANIZATION of well child conferences calls for community teamwork. They are at the present time promoted in those areas where fulltime health units are functioning. The medical director of the local unit solicits the support of the practicing physicians, as well as that of interested civic groups, such as the Junior Service League, Parent-Teacher Association, Panhellenic Club, church guild, and similar groups. These people participate by providing volunteer assistance in the conferences. Cooperation of the State Health Department, including limited financial aid and consultation service, may be obtained through the health unit personnel.

The medical director, the sponsoring group, and the public health nurse usually work together to locate adequate housing for the conference. The health unit building offers a choice spot if it is centrally located and provides the necessary facilities. We believe this to be a good means of encouraging families to go to the health unit for service. Frequently, however, it is expedient to establish a conference in other locations in order to be convenient to the families to be served. Space divided into four rooms on the ground floor in a building which meets sanitation standards is usually recommended. The building should be clean, as attractive as possible, and should have adequate heat, light, water, and ventilation. The necessary equipment may be furnished jointly through State Health Department funds and local support.

We recommend that well child conferences be organized only in areas where the public health nurse, through her home visiting program, has built up a caseload of infants and preschool children in sufficient numbers to feed a bi-monthly or weekly session of the conference. When conferences are maintained on a monthly basis sponsoring agents as well as parents soon lose interest in the project.

We have found conference sessions are most successful when conducted on an appointment basis. A team of physician, nurse, nurses aide, and volunteers, when possible, can serve adequately approximately ten children in the usual three-hour conference period. If longer hours are observed more workers are needed and more children may be served. Appointment booklets are given for each child; most initial appointments to new children should be given to the parent by the public health nurse on a home visit prior to the child's enrollment at the conference. The home environment is ideal for opening the child health record and obtaining a complete and accurate history. At this time the nurse may fully explain the longterm service the conference offers. Such a plan frequently avoids misunderstanding on the part of the parent as well as confusion of this service with that of immunization clinics.

On the well child conference day the nurse asks the unit clerk to pull the conference records. The nurses aide goes to the building early and puts the equipment in order. A volunteer may serve as registrar. She checks the appointment cards as the children and parents arrive. She also pulls the individual record and necessary immunization cards and clips them to the record. The child plays with toys under the supervision of a volunteer until his name is called, when he goes to the weighing room. He is undressed by his mother. He is weighed, his height measured, his temperature checked by the nurses aide, who notes her findings on the record. The aide observes the child while doing these things for him. If he has an elevated temperature, a rash, a flushed face, or similar signs, the nurse sees the child. If the child appears ill he is immediately sent to his family physician for care.

For example, in one conference the following incident occurred:

"Hold still, Jane, while I get your things off and the aide can see how much you have gained."

"But they *itch,* Mommie," said Jane, as she squirmed and rubbed the numerous insect bites on her arms and legs.

The aide stepped to the door and said, "Miss S, will you come and see how Jane has grown!"

The nurse, Miss S, came at once.

"Well, my goodness, you certainly have grown to be a big girl, Jane. It must be that milk you drink every day. Is it?"

"Yes, Miss S, I drink lots n' lots of milk and I eat lots of veg—well, beans n' greens, too."

"That's fine, Jane. How long has she had these places on her body, Mrs. B?"

"About four or five days, Miss S. They're mosquito bites and Jane sure does scratch them, then they get infected and that brown crust comes on them, and they get sore. They look awful," said Mrs. B.

"Perhaps that's it," Miss S stated, "but it could be a skin infection too. Could you take Jane to your family doctor now, Mrs. B? You remember I explained that we cannot give treatments here, and I believe Jane needs medicine to heal those sores."

"Why yes, we can do that if you think best, Miss S. Come, Jane, let's get dressed and go and see our Doctor J."

Later Mrs. B called the nurse to tell her that Doctor J had diagnosed the skin condition as impetigo—an infectious skin ailment, and one which could develop into something serious if not treated in its early stages. She was most grateful to Miss S for her guidance.

BEFORE THE arrival of the physician the nurse takes an interval history on each child in an effort to discover what has happened to him recently. She records her findings on the child's record for the convenience of the physician. Special attention is given to accounts of marked change in behavior.

If a second nurse is assigned to the conference she usually fills the early hour of the conference with planned instruction for the parents. Demonstrations such as those on formula preparation, bathing the baby, introducing solid foods, selected playthings, and self-help clothing may be given. Discussion of behavior problems such as teaching a child to share, sibling jealousy, temper tantrums, bed wetting, thumb sucking, and similar subjects are eagerly received, and the parents' contributions to these discussions are most enlightening. The volunteer worker usually entertains the children in the playroom so the classroom may be undisturbed by the children's chatter.

When the physician arrives he examines each child and instructs the mother about child care. He may order a new formula, new foods, and vitamin therapy; he often suggests the child should be taken to the family physician for further study and care; he orders immunizations as they are indicated. For children who show a tendency toward behavior conflicts, the parent may be encouraged to seek help from a child guidance center if one is available. He frequently helps mothers with minor behavior problems.

One mother was having quite a problem with her three-year-old daughter since the arrival of the new baby boy. Kaye had become a meddlesome, noisy, quarrelsome, stubborn, negativistic child. There was a complete personality change and the parents could not account for it. The physician helped the mother to see that the child was behaving in this manner to get the attention of the parents. She was afraid the new baby had taken her place in their affections. With the physician's guidance the mother and father made a special effort to give Kaye more attention. Father took her with him to help him buy groceries. Mother encouraged her to bathe her doll at the same time the baby was being bathed. Kaye was allowed to bring diapers to mother for the baby and was praised for her help. Father read stories to Kaye at bedtime—held her in his lap and frequently told her how important she was to both mother and father. Gradually the child began to feel more secure and lost her feeling of antagonism for the baby.

After the physician has finished the public health nurse again interviews the mother to be certain she fully understands the physician's instructions and has the ability to follow them. If because of inadequate funds, lack of equipment, or similar reasons the

mother thinks she cannot follow the recommendations, the nurse helps her plan ways and means of doing so. Other community facilities are known to the nurse and she feels free to refer appropriate cases to them. After the mother is certain of her next step in the care of the child she is sent back to the registrar, who makes another appointment for the child.

Mrs. J told the physician that little Sue, aged four, was quiet and listless for a couple of hours every afternoon.

Dr. K asked, "Does Sue have fever when she is quiet?"

"I have never taken her fever, Doctor," answered Mrs. J.

"Well, let's take her temperature every afternoon for a couple of weeks, and then we will be able to decide what course to follow," said Dr. K.

"Yes, Doctor K."

When the nurse discussed the doctor's orders with Mrs. J, she noticed that Mrs. J was pretty noncommittal.

"Do you think it will be possible for you to take Sue's temperature each afternoon, Mrs. J?"

"Well—no, I don't guess I can, Miss S. I can't read a thermometer, and we don't have one," answered Mrs. J.

The nurse arranged with the volunteer worker who was a neighbor of Mrs. J's to take Sue's temperature each afternoon. The nurse lent a thermometer to Mrs. J from the loan closet. She also made an appointment with Mrs. J for a home visit on the day that Miss S usually visited that community, at which time Mrs. J would be taught to read and care for thermometers.

THROUGH COMMUNITY interest and sponsorship a valuable service to a family may be given. Take the case of Johnny B. Johnny was three years old when the nurse found him one day. She had stopped to ask the location of another family when she saw Johnny running across the porch. He fell without any apparent reason. The nurse visited with the mother a few moments and watched the child at play. He was thin, pale, but fairly active. He was rather unsteady as he ran and walked. The mother stated that Johnny was clumsy and awkward—more so than her other five children had been at his age. Her husband was a carpenter and worked hard, "but his work comes by seasons" and there were times when money and food were scarce. The family had a physician whom they called when illness was severe, but they could not afford to go to him often, even though he never pressed them for payment of his bill.

The nurse explained that well child conference service was available in that county and asked that Johnny be brought for health supervision. An appointment was made for the following week.

Johnny seemed to enjoy being with the other children in the conference. He was considerably underweight and underheight. When the physician examined the child he found that Johnny had rickets. The cause of the deficiency was explained to the mother and a list of needed foods and vitamins was recommended.

Following the physician's examination and instructions the nurse had a private interview with Johnny's mother. Community facilities which could be called upon for financial assistance were explained to her and the procedure for application for help was given. Johnny was closely observed for several months. The nurse spaced her visits to the home between conference visits to be certain the mother understood the physician's orders and was following them accordingly.

This is one way of improving the wellbeing of our children—of helping to develop a future citizen who is healthy in mind, body, and spirit—through medical and nursing supervision, parent education, and community cooperation.

This article appeared also in the *Texas Health Bulletin,* August-September 1951.

Working Together to Meet the Needs of Diabetes Patients

FRANK H. JENNE, M.P.H.

THE ALERT public health nurse recognizes the important needs of diabetes patients whom she visits. She observes their need for adequate medical care, for instruction in the use of insulin, for instruction in diet and in personal hygiene, their need to develop a philosophy that will enable them to live successfully with their disorder. She also observes the need for more rational attitudes on the part of relatives and friends, employers, and the community at large.

Since 1935 Cincinnati has been making an organized and determined effort to meet these needs. Physicians, nurses, dietitians, social workers, and other professional and lay people concerned with diabetes are working together for better health and longer life for diabetes patients. The Council on Diabetes, a wing of the local health council (the Public Health Federation) is the workshop where their plans are developed and coordinated. The Cincinnati council was antedated by other groups in New York, Philadelphia, Boston, and London, but it is still unique in its concept of the various professions and the laity working together.

In its monthly meetings, through observation and statistical studies of diabetes mortality, the council has established that the needs mentioned are valid and worthy of organized attention.

The need for adequate medical care was amply revealed in 1940 and 1950 by detailed studies of the circumstances of all local deaths from diabetes acidosis. In the 1950 survey, for example, two of the fifteen fatalities were ascribed to complications beyond medical control. Seven were known diabetics who had stopped seeing their doctors. In the other six acidosis developed under the physicians' attention.

The council encourages local hospitals to conduct diabetes clinics in the outpatient departments so that no diabetic need go without care for financial reasons. It promotes high quality of care by physicians in private practice through scientific meetings and distribution of literature in cooperation with the Cincinnati Academy of Medicine.

It stresses constantly to diabetics the need for regular visits to the clinic or physician. This is done largely through the lay Diabetes Association sponsored by the council, of which more will be said later.

The nurses in our clinics and in our Visiting Nurse Association play a tremendously important role in instruction of the patient and his family. Through the council, nursing has become involved in every phase of the organized educational program.

In 1940 the council took its first step toward an organized program of education for the diabetes patient. It sponsored the diabetes instruction service, established in connection with the diabetes clinic at Cincinnati General Hospital. All local physicians were notified about the new service, which included laboratory work and group and individual instruction in insulin injection, diet, and personal hygiene. Physicians, nurses, diet therapists, and chiropodists take part in instructing diabetes patients. The service was not, and is not, limited to patients of the clinic class, but is made available at a nominal charge to anyone, on referral from his physician. Patients are sent back to their private physicians with complete reports of all findings and instruction and the physicians refer them to the service for periodic check-up and instruction.

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Every diabetes patient and his relatives may join the lay Diabetes Association sponsored by the council. Organized in 1946 the association affords every diabetic an opportunity for morale-building social experiences and for what may be called a "graduate course" in living with diabetes. There are an estimated 5,000 known diabetics in the Greater Cincinnati area, and the association's membership list is now about 600. Physicians, nurses, dentists, chiropodists, pharmacists, dietitians, and successful diabetics have appeared before the group to give talks and demonstrations and answer questions. There is always full and free discussion; some of the questions reveal basic insecurities; others represent a thirst for knowledge that will help in achieving as normal a life as possible. The association holds a picnic every year at which food is served cafeteria style. This gives the diabetic an opportunity to demonstrate his mastery of the technical intricacies of his diet and, more important perhaps, his achievement of a degree of emotional adjustment to food and what it means to him.

ANOTHER ACTIVITY of the council which has an educational objective is the camping program for diabetic boys and girls. This program has been carried out since 1942 through the cooperation of the Girl Scouts, the YMCA, and the Children's Hospital Diabetes Clinic. The clinic selects patients for camping and, before the Scout and YMCA camps open, the clinic staff indoctrinates the camp staffs in the special needs of the diabetic campers. Since the clinic children are all on a liberal diet regime the only special considerations they need are opportunities for urine testing, insulin injection, and immediate recognition and treatment of any diabetic emergencies that might arise. The experience is of great help not only to the diabetic youngsters but also in creating an enlightened attitude toward diabetes among their nondiabetic fellow campers.

Diabetic instruction to the patient and his family in the home is given by the visiting nurses. The VNA, through its representation on the council, keeps its part of the program attuned to those of other agencies.

Important to the wellbeing and care of diabetes patients is the booklet, Food Values in Terms of Household Measures,[1] which has gained increased acceptance in recent years and has helped free many diabetes patients from the tyranny of a weighed diet. The booklet plays a small part in the prevention of diabetes, too, since many physicians prescribe it for use in connection with reducing diets. The council is now making every effort to popularize the newly developed Meal Planning with Exchange Lists,[2] the simplified system of diet instruction developed jointly by the American Diabetes Association, the American Dietetic Association, and the U. S. Public Health Service.

The council, as the local affiliate of the American Diabetes Association, encourages diabetics to subscribe to the ADA *Forecast*,[3] a magazine for diabetics published by the ADA. It prepares a newsletter which is mailed to members of the lay Diabetes Association. It prepares posters and news releases and utilizes other mass media for education of the general public to encourage early detection and treatment of diabetes and constructive attitudes of relatives, friends, and employers toward diabetics. Police recruits are trained to recognize and deal properly with diabetic emergencies.

Recently the council sponsored a gigantic "Diabetes Day" program. About twenty of the most eminent medical authorities on diabetes, members of the Council of the American Diabetes Association, were brought to Cincinnati for the day. In the morning they visited the research facilities at Cincinnati General and Children's Hospitals. In the afternoon three of the group made appearances on radio and television. A capacity crowd of 500 jammed a downtown auditorium for a question and answer session with the visitors. Afternoon papers carried interviews with Dr. Charles H. Best, co-discoverer of insulin, and a member of the panel. In the evening physicians, nurses, dietitians, and other professional workers heard a scientific question and answer panel.

Through such activities the council attempts to meet some of the pressing needs of diabetes patients in a way that calls forth the

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The Supervisor Develops Leadership Among Staff Nurses

HELEN E. DUNLAP, R.N.

LEADERSHIP IS THE name for that combination of qualities by the possession of which one is able to get something done by others chiefly because through influence they become willing to do it." Although Ordway Tead was referring specifically to leadership in industry this definition also expresses the philosophy behind supervision in public health nursing. As supervisors in our day-to-day contact with staff nurses we must be ever cognizant of this combination of qualities, for today's staff is the source of supply for tomorrow's leaders.

There are certain qualities which are fundamental characteristics of every public health nurse: nursing knowledge, optimum health (which includes emotional stability) good grooming in and out of uniform, and an active participating interest in things in and outside her profession. Over and above these the supervisor should be alert to the following additional characteristics which will develop into leadership qualities when the worker is given guidance in the proper direction:

1. An ability to work and get along with people—a warmhearted feeling for people. This includes patients, professional and nonprofessional members of the community, as well as coworkers.

2. An ability to assume and carry out responsibility—"dependability in performing well those tasks for which they are responsible."

3. An interest in agency activities above and beyond the routine assignments.

4. An interest and initiative in the development of new projects.

5. An interest in furthering her professional education.

6. An acceptance as a leader by her own group.

7. A sense of "professional perspective" to be able to evaluate oneself and one's work objectively and to be able to differentiate between the important and trivial.

There are many more qualifications which a potential leader develops with experience. Therefore, we must be on the alert for such emerging qualities. We must be aware of the challenge we meet in the new staff member and also in the older staff member who shows leadership traits as her experience widens. To begin with, we must have a nurse interested in furthering her career. In many instances it is the responsibility of the supervisor to stimulate an interest in the young nurse in developing leadership characteristics. The job of training leaders is a long and hazardous one for an agency—long because of the necessary theoretical preparation, and hazardous because of losses owing to marriage and family raising.

How can this interest be stimulated? First, as supervisors, we must understand the nurse. We should know her strong points and her weak points; we should know her background and her goals; we should know how she can be encouraged to make the most of opportunities.

Second, we must make sure that the nurse has the chance to accept a new experience—a new experience perhaps in the light of a special interest or ability. In offering the experience as a challenge to her we must make certain she is in position to accept the opportunity. We must see that her schedule is readjusted, that references and other resources are available, and that conference times for consultation are planned. Nor can we lose sight of the fact that all this development is built around the service to the patient and the community as a function of the agency. There-

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fore, learning opportunities must be real, not manufactured or artificial.

Let us say that this new experience is a planned conference to be conducted by the nurse. The supervisor must be willing to devote time and effort to help the nurse plan and organize the conference and to understand her function as leader. The next time the nurse conducts a conference she will be expected to be able to take independent action and follow through, with only confirming guidance from the supervisor. We must guard against spoonfeeding for that kills initiative. If the nurse is aware of the supervisor's confidence in her she will go ahead, given the proper qualifications.

Third, the supervisor must remember always the principle of individuality, that each human being is unique, no two exactly alike, and consequently each learns at her own rate of speed; that each has unique qualities of leadership to be developed. Each nurse will progress at her own pace and there can be no time limit put on her step-by-step progress. This is a most important point.

Fourth, the supervisor must offer encouragement by review of problems as they arise, by offering constructive suggestions as indicated. The supervisor will set the stage, so to speak, by preparing the staff to accept the increase in seniority given the nurse who is being trained in leadership, smoothing over the sharp edges that can result when one staff member is given priority over another, thus eliminating those petty jealousies which sometimes come from misunderstanding of administrative decisions. This will assure cooperation among the staff, for it helps morale when people know that leadership is recognized and that there are opportunities for their growth and development, too.

How one agency has managed leadership development

Perhaps I can make these points clearer by telling you what we do in our agency. It is our policy to train and promote staff nurses to the supervisory group. When a nurse is considered for advancement a conference between the administrator and the supervisors is held to determine whether the area in which the nurse is working is challenging enough in so far as her abilities are concerned. If it is not and if the opportunity is available the nurse is assigned to a territory which requires more from her professionally and personally—for instance, a district where there is a school health program or a child health conference. If a change in territory is not expedient she is given the first opportunity that arises for group teaching, such as expectant mothers' classes, home nursing, and girl scout classes. This means that the nurse must rearrange her bedside caseload; that she must have more direct contact with members of professions other than nursing; that she must work with volunteers and with the community on a broader basis than her earlier experiences permitted. For example, the nurse who carries responsibility for special activities takes part in the education of board members; she attends specified board meetings and interprets the agency's function and the working plan of the particular program she is interested in at the time.

Successful experiences with special programs will encourage the nurse and she will have more confidence in her ability to assume the next step of senior nurse activities. These duties include the "big-sister" job for the new staff nurse—taking care of a new staff nurse assigned for field observation and assisting the new staff nurse to adjust to office routine. The senior nurse takes a major part in the development of inservice education programs and presides at staff education meetings; she serves as staff representative on the agency's public relations committee or on its personnel committee.

She steps from this category to become the senior advisory nurse, in which capacity she is given responsibilities in work assignment for the general staff. She takes part in the orientation of new staff by demonstrating procedures and by supervising the demonstrated technics in the field, writing the evaluation, and holding the postfield conference.

The next step up is that of assistant supervisor, in which position the nurse's field work is cut in half. This time may be occupied by a special project—an industrial or a school health program or a child health conference.

She has full supervisory responsibilities for indicated staff members. Her contact with the communities served by the agency is widened through committee assignments; to be more specific, some regional committees (from townships and boroughs in agency territory) are interested in various aspects of the agency work and she attends some of these committee meetings to give reports of current agency activities. As assistant supervisor she assists in organizing community activities related to the work of the agency and can represent it or public health nursing in general on committees sponsored by the health and welfare council, the community chest, the state nurses' association, et cetera. She assists in the preparation of agency reports to its board and to the community chest. She relieves the supervisor during her absence. At this point you may notice that the learning of the potential leader has taken on some aspects of administration. We think this is extremely important in the overall picture of agency work.

Some of the limitations within an agency in developing leaders from staff

Each agency should view its situation objectively before deciding how it can work out a program for developing leaders from staff. The expense must be considered—definite, but so intangible that it cannot be itemized in a budget; it must be absorbed somehow. What are the preparation and the background of the supervisor; the resources available to her for her guidance; the ratio of staff to supervisor?

Not all staff nurses have the qualifications or inclination for leading. When we have a nurse who is not a potential leader but who is an excellent staff nurse we should thank heaven for her and hope she stays forever.

There is always the chance that something unforeseen may happen in a campaign which will limit the step-by-step advancement we have mentioned; because of some personal incident which affects her professionally the nurse may never get beyond the senior advisory nurse stage. Again, we should be pleased, knowing that senior advisory nurses are an asset to any organization. On the other hand, it may be that the agency cannot expand to accept the nurse in the advanced position for which she has been prepared. The decision of the administrator or supervisor must be objective and unselfish at this point. The fostering agency will not always reap the benefit of its careful training of the individual. The administrator must be aware of the limits of the agency and be prepared to encourage the nurse to seek opportunities elsewhere. That's a job well done—that's progress.

This paper was presented at an institute for supervisors in October 1951 sponsored by the Pennsylvania Organization for Public Health Nursing.

Needs of Diabetes Patients

(Continued from page 452)

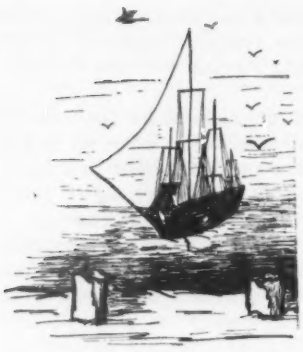
best efforts of every profession and agency that has a contribution to make—and in the most efficient and effective way possible.

REFERENCES

1. Diet Therapy Section, Cincinnati Dietetic Association. Food values in terms of household measures. 312 West Ninth Street, Cincinnati 2, Public Health Federation, 1948 (revised). 20 cents. Lists food values in terms of cups, tablespoons, et cetera.

2. Committees of The American Diabetes Association and The American Dietetic Association in cooperation with the Public Health Service, Federal Security Agency. Meal planning with exchange lists. 216 North Dawson Street, Raleigh, North Carolina, Health Publications Institute, 1950. 45 cents for introductory kit including diet lists and physician's diet card. A simplified form of diet instruction utilizing milk, vegetable, fruit, bread, meat, and fat exchanges. Provides a widely varied diet with no necessity for complicated mathematical computation.

3. American Diabetes Association, Inc. *ADA Forecast*. 11 West 42 Street, New York 18, American Diabetes Association, Inc. Subscription two dollars a year (six issues). Recommended for diabetes patients and nurses who work with diabetics. Features include helpful recipes, advice on meal planning, and other material related to living with diabetes.



Why British Sailors Are Called Limeys

This is one of many stories the author has used in working with young boys in boarding school. She found these youngsters wanted to know why medications were given, who discovered certain medical facts, et cetera. Another story, about Jenner and vaccination, has been used by the federal government for education of children in occupied areas.

MURIEL FARR, R.N.

JAMES COOK was tired, hot, and dusty. As he sat under the hedge to rest he wondered if he could ever walk the last mile of his journey. One mile farther also meant another one coming back, and besides he had a beating to look forward to at bedtime for being late. Was it worth it, just to look at the sea?

James was thirteen years old. He had worked hard in the Yorkshire potato fields since he was five. A month previously his father had apprenticed him to a merchant, a harsh man who gave him many beatings. James often thought of running away, but where could he go? The most exciting thing in his life had been a sailor's visit to the shop. He told him such wonderful tales of ships and the sea that James had decided to walk to the coast on his first free day and get a look at the ocean and the ships.

As he sat wondering whether to go on or turn back, he heard the clop-clop of horses' hoofs and a merry voice singing, "Bring out your pots and pans for old Tom the Tinker."

A shaggy horse was pulling a cart hung around with pots and pans of all descriptions. The driver was a cheery brownfaced man. As James moved to get a better look the tinker caught sight of him.

"Hi there, boy. Want a ride to Whitby? I'm a lonesome sort of cove and I like company," he called.

"Will you be going near the water, sir?"

"Right to the waterside. I have pots and pans here for His Majesty's ships. Not shipping as a cabin boy, are you? It's a hard life, they say; shouldn't want it for my son."

James climbed on to the cart. The tinker's words made him thoughtful. Was that all there was to going to sea, just to go to the port and say you wanted to be a cabin boy? The old sailor had said they could never get enough boys because of the hard work and the beatings. But what had his life ever been but hard work and beatings?

Soon James heard a deep booming noise. "Is that thunder? The sky looks clear."

"Thunder of the sea, not the sky," laughed the tinker. "Easy to tell you're a landlubber."

James was so excited that he nearly fell out of the cart in an effort to see everything. The masts of the ships riding at anchor, the shrill cry of the gulls, and the smell of the tar made him decide that here was where he belonged.

That evening the merchant shouted for James, threatened him with a beating for hiding, and another for being late. James never got those beatings. He had run away to sea.

He found life as a cabin boy harder than

that as a farm boy, harder than that as an apprentice. He had little to eat, the food was salty and often spoiled, the sleeping quarters were crowded and dirty. But James was happy. He was a real sailor. He never deserted the sea, and in time became one of the greatest navigators of the world.

His first ship was only a grimy barge which took coal from England to the northern European countries. He listened to the tales that the old sailors told: tales of the South Seas; of strange animals, of brilliant flowers; of fruit the like of which was never seen in England or in the cold North Sea countries. He learned anything and everything the men would offer to teach him—mathematics, astronomy, geography. Soon he rose to be a deck hand and advanced step by step to become master of his own ship.

Two hundred years ago the dangers of the sea were great. Pirates roamed the seas, ready to seize any ship with a valuable cargo. Many sailors lost their lives or were taken prisoner. The ships were small and in danger of being wrecked on reefs or battered by storms.

BUT THERE was one danger greater than all of these put together: scurvy. Scurvy is a disease that killed sailors at the rate of one or two a day on long voyages. James Cook noticed that the longer the voyage the more cases of scurvy there were. It was one reason so little of the South Seas had been charted. A sailing vessel from England took one or possibly two years to sail through that region. Most of the voyages had to be given up because so many of the crew died of scurvy.

It was Cook's dream to sail new seas, to discover unknown lands, to risk hardship and danger. In 1768, when he was forty-one years old, he was appointed to conduct an expedition to the South Seas. This was his great opportunity. He must not fail as others had before him. And to succeed he must conquer scurvy.

He read *Treatise on Scurvy* written by James Lind. Lind thought that fresh fruits and vegetables had something to do with scurvy, both with its prevention and cure. This had never been proved, but Cook took aboard as many fruits and vegetables as possible. He insisted upon absolute cleanliness and fresh air in the sailors' quarters.

His ship Endeavour was away for over two years. In his account, *The Voyages of Captain Cook*, careful notes were made of every place the ship stopped. Fresh fruits and vegetables were taken on at every possible place. A record of each case of scurvy—when and where it occurred—was made.

Cook did not leave a note telling when he got the idea that freedom from scurvy had more to do with the amount of fresh vegetables eaten than with cleanliness. However, we know he did come to this conclusion. He had been at sea for a year before scurvy appeared and this was after a long period in which the ship was unable to take on fruit. This was by far the best record of any ship in the Royal Navy. His interest was shown by such entries as these: "Limes. These are excellent and to be bought at twelve pence per hundred." "Sweet oranges. These are very good, but while we were here sold for six pence apiece."

On his second voyage he had an even better record. He undertook to chart the southern hemisphere, or such of it as was known in that day. Again he kept a careful record of everything, even to describing the animals and plants seen. The first sight of a kangaroo caused great excitement since no one had known until then that such an animal existed.

This voyage lasted three years and only one man out of a crew of one hundred and eighteen was lost from scurvy. It is true that others before James Cook had thought that fresh fruit and vegetables prevented scurvy, but to him goes the credit of actually proving this to be the truth. Cook remarks that "Rob (juices of oranges and lemons) is an antiscorbutic we were not without. The surgeon made use of it with great success."

He wrote a paper on the prevention of scurvy and was given the Copley Gold Medal for the best experimental paper of the year. The Admiralty raised him to the rank of captain. In 1795 a law was passed that every man in the British Navy was to have a ration of fruit juices. Since limes were mostly used the British sailors were nicknamed "Limeys" by sailors of other countries. The section in

London called Limehouse got its name from the days when fruit for the ships was stored in that neighborhood, close to the waterfront.

When Pasteur and Koch discovered germs many years later many people thought that germs were the cause of all ills. Still later it was discovered that there were some people who, like the sailors, became ill and died although there were no disease germs in their blood or bodies. Why were they ill? Gradually it was found that there were substances missing in their bodies. There were substances in food that were needed for good health. A man could get enough to eat to prevent hunger, yet fall ill. Another who ate less food, but a better variety, kept well. By experiments such as those carried out in a simple form by Captain Cook it was discovered that certain substances must be eaten to maintain life and health. The discoverers named these substances "amines" then added "vita," which means life. Actually Captain Cook can be called the first discoverer of vitamins.

Miss Farr is chief infirmary nurse, Bryn Mawr College, Bryn Mawr, Pennsylvania.

Medical Records in Civil Defense

A uniform method of tagging casualties following an enemy attack upon American cities and of providing medical information for first aid stations and emergency hospitals was announced recently by the Federal Civil Defense Administration.

In contrast to the usual detailed medical records prepared by trained personnel in normal times, the civil defense medical forms take into consideration the fact that some of them will be filled out by persons with little or no training and probably under the most adverse conditions. The forms will be simple and their preparation will not consume time needed for the treatment of the injured.

The record system includes a medical tag for every injured person who needs further medical care, and for dead casualties; a first aid station log; an index and information card for hospital and outpatient departments; emergency hospital clinical record and record jacket; and hospital disposition log. The record will accompany each casualty from the time he is first discovered until he is discharged. The individual can be identified by the recommended FCDA identification tag if he cannot talk.

For the new FCDA publication, Organization and Operation of Civil Defense Casualty Services, send to Superintendent of Documents, U. S. Government Printing Office, Washington 25, D. C. Price 15 cents.

Nutrition and Civil Defense

HOMER N. CALVER

The author was one of twenty-five delegates from the United States who attended the Combined Conference on Administrative Problems of Food Aspects of Civil Defense held in London in December 1951. He reports some of the significant points made at the meeting. The delegates visited the British Ministry of Food experimental feeding kitchens and food experimental factory and saw demonstrations of food salvage, emergency cooking, and improvised sanitary equipment.

IF BOMBS should fall on one of our large cities vast numbers of civilians would be left without the means to prepare food or the money to buy it. Mass feeding on a scale hitherto unknown would have to follow. And this gigantic, widely dispersed, and, at best, disorganized job of feeding thousands under emergency conditions would inevitably offer alarming possibilities for the outbreak of food poisoning and the spread of foodborne disease. Individuals requiring nutritional therapy would be in a particularly difficult situation.

To illustrate the feeding problems that would face a community following a heavy air raid, the following description was given by a British deputy food officer who served in one of the worst hit of English towns:

Water supplies are cut off. Cooking facilities which depend on gas and electricity, nonexistent. A large proportion of food shops and commercial eating places completely destroyed or seriously damaged. Food stocks in the city depleted. Several bakeries destroyed and those remaining unable to operate because of lack of water and power. Thousands of people homeless, tired and hungry, and their ration books, which form the basis of the rationing system, destroyed. Transportation rendered almost impossible by bomb craters and delayed-action bombs. No telephones functioning. On top of all this, the local civil defense food office damaged, its staff carrying on by candlelight. Under these conditions the feeding of a hungry city assumes a complexity and magnitude almost beyond description.

Every place where food is being served to the public could, under these circumstances, become a point of health danger. Sanitation troubles are unbelievably augmented if utilities are knocked out. If the water supply is disrupted by broken mains or if water is contaminated—as it could be in an atomic war—this precious fluid may have to be trucked in from outlying areas and carefully conserved for drinking purposes only. This would mean that in mass feeding centers, in commercial restaurants still intact, even in hospitals, food service personnel would be sorely taxed to keep up routines regarded as essential for safety.

British delegates, who stressed repeatedly the vast amounts of water that are necessary to clean pots, pans, plates, cups, and cutlery in emergency feeding centers, underscored the value of paper cups and food dishes as mass feeding equipment. Their experience with paper equipment at Coventry after heavy raids proved its usefulness in conserving water,

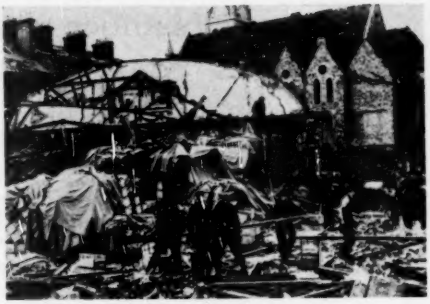
Mr. Calver, former executive secretary of the APHA, *organized and is now chairman of a Public Health Committee for the Paper Cup and Container Institute. He is an honorary fellow of the Royal Sanitary Institute of Great Britain and a member of the Society of American Bacteriologists. He attended the London Conference as a special adviser to the Federal Civil Defense Administration.*

reducing labor, facilitating quick service, and yet maintaining cleanliness. Widespread use in Britain during the war was impossible because of British paper shortages, but delegates were interested to learn that in the United States 25,000,000 paper items have been stockpiled by the paper cup and container industry in twenty presumptive target areas for just such emergency uses in this country.

PUBLIC HEALTH controls during an emergency would of course be far easier if pre-attack civil defense training of regular and volunteer food workers emphasized basic principles in sanitary food handling. All precautions should be taken to assure that food is both wholesome and safe. Personal cleanliness, the invariable use of clean food containers, proper food storage, careful separation of refuse, and so on, would help to avert serious outbreaks of food poisoning. Handling of perishable foods such as meats, frozen foods, milk, would become troublesome if refrigeration and cold storage were cut off because of disrupted electric power. Menu planning should provide for the use of perishables first; canned and staple goods should be saved for later consumption.

The detection of spoilage, contamination, and radioactivity in food also falls within the domain of public health. The British urged the prompt application of intelligent salvage technics to damaged foods as a means to recover great quantities which at first glance often appear a total loss. They estimated that 75 percent of the food discarded after the first air attacks could have been saved by methods later applied. Food fit for human consumption or for reconditioning was extracted from hopelessly damaged warehouses, retail shops, and factories. On the other hand, careful supervision of food supplies quickly led to the discovery of food unfit for human consumption which would have been highly dangerous if unwittingly used. Monitoring foods exposed to atomic blast to discover radioactivity would be an important function in an atomic war.

In the United States the health services



An example of successful British food salvage operations during World War II. This building in which 650 tons of miscellaneous foodstuffs were stored was completely demolished in the bombing and everything inside seemed a total loss. Six weeks of careful work resulted in recovery of 636 tons of food.

branches of the state and local CD organizations will be operated by the official state and local health agencies. In the event of an atomic disaster the health services branch is charged with recommending the type and amount of food for the general population, for essential CD workers, and for special groups such as infants, pregnant women, and the aged. Nutritional therapy connected with treating burns, radiation damage, shock, et cetera, would also fall, at least in part, on the shoulders of the public health group.

Diabetics, persons with ulcers, and others normally treated with special diets would receive control medications but would not be able to have special diets until normal feeding conditions returned. They would share with the rest of the uninjured population the daily per capita allowance of 2,000 to 2,200 calories. The Federal Civil Defense Administration believes that even if substantially less than this recommended allowance were given to the general population, specified vitamin or mineral deficiencies would not develop within a thirty-day period in persons previously well nourished.

For CD operation to be effective planning must be done at the local level. In a new war survival would depend on the resourcefulness of the individual and of the community; and by the "community" very small areas are meant—a street, a neighborhood—rather than a city.

Methods of Providing Income for Old Age

MILTON H. GLOVER

EVERY NURSE should plan for old age income, and the sooner she starts the better. Many nurses do not think about this until they are well along in life and then it is frequently too late to do much about it. Even the married nurse should plan for this, because sometimes misfortune overtakes her.

There are several methods of providing an income for old age. Some are better than others. They might be listed thus:

1. Personal savings and investments.
2. Personal annuities.
3. Employer's and employee's retirement plans.
4. Social Security.

If a nurse can build up a substantial sum by all these methods she is to be congratulated, but it is difficult to achieve them all under conditions as they are today.

Let us look at each of these methods and see how they work out.

Personal savings and investments

Many nurses, of course, have savings accounts against "a rainy day" and this is wise. Some may save the equivalent of a few months' pay and a few, by dint of great thrift, may accumulate a sum equal to two or three years' pay. But few can save enough. A few nurses may own bonds, stocks, or real estate, but if a nurse expects to invest in this way she should get sound advice because there are many risks in this field over which she has no control. It is true that earnings on some types of investment are higher than others, but those with the greatest safety have the lowest income.

But the nurse who only saves money in a bank or buys investments wisely still has a problem about finances in old age. She cannot tell how long she is going to live. Will she have to stretch her capital and income over five years, ten years, or twenty years of old age? If she reaches age sixty-five, her average life expectancy will be about seventeen and a half years and she may live to be a hundred. In order to provide herself—out of the amount she has saved plus interest—with an income of $100 a month for seventeen and a half years a nurse will have to figure on an accumulation of $21,000. Few nurses, with all their other obligations, can accumulate that much without the greatest sacrifice.

Mr. Glover is senior vice president of the Hartford National Bank and Trust Company.

Personal or individual annuities

An annuity is a guaranteed income, payable as long as you live even if you live to be ninety or a hundred years old.

Personal or individual annuities are purchased from an insurance company, with premiums payable either in a lump sum or by installments. The purchaser decides how large an annuity she wishes to purchase and whether she wishes an annuity with or without a refund to her heirs in case of death. Annuities with a refund clause in case of death generally cost more than those without. Usually, after allowing for interest earnings, it requires about $18,000, if paid in a lump sum at age sixty-five, to purchase an annuity of $100 a month for a woman—and about one half that amount for an annuity of $50 a month. For a younger woman the amount required is somewhat less because her premiums earn interest.

Employer and employee retirement plans

Nursing associations and many hospitals recognize the difficulty the individual nurse has in saving such sums as these. At the same time they are aware of their responsibility to see that a nurse has a guaranteed income for life when she becomes too old to work. Therefore, they have undertaken to provide for such old age income through a systematic arrange-

ment under which the employee and the employer contribute jointly.

A few employers have undertaken to set up plans of their own to do this, but by far the greater number are participating in a larger program such as that provided by the National Health and Welfare Retirement Association. There are certain risks and disadvantages involved in operating small plans which are overcome when a large group of employers cooperate.

Nearly 300 visiting nurse associations and about 2,000 other health and welfare agencies are using the National Health and Welfare Retirement Plan. One important feature of the National Plan is that a nurse may transfer to another job without losing her benefits if she holds her certificate. If she transfers to another one of the 2,300 employers in the plan she usually continues her benefits and contributions without interruption. Some retirement plans do not offer these provisions.

If a nurse contemplates taking a position with an agency which offers a retirement plan she will do well to inquire into the provisions of that plan with respect to her rights if she terminates her work. In some plans if she contributes for less than ten years she can merely withdraw her own contributions when she resigns. In a plan really designed for the welfare of the nurse she should be able to retain the benefits arising from the employer's contributions when she resigns, regardless of her length of service, provided she leaves her own contributions in the plan for retirement purposes.

Social Security

Most nursing associations and hospitals are now covered by Social Security—and they should be. Under Social Security the employer and employee each pay Social Security taxes of 1½ percent. In time this rate will probably be increased.

A nurse must be covered by Social Security for at least half the time between January 1, 1951, and when she becomes sixty-five years of age to qualify for an old age benefit—except that a nurse forty-five years of age or younger at January 1, 1951, will qualify in ten years if she continues to be covered by Social Security throughout that period. However, if the nurse is covered for a shorter period than ten years she will not be eligible for an old age benefit.

To receive a maximum old age benefit under Social Security a nurse must work to age sixty-five or later. No old age benefit is payable until she reaches that age. If she cannot live on her Social Security benefit and has no personal assets she will have to continue working if she can, and pay Social Security taxes with her employer.

This point illustrates the value of having a supplementary plan in addition to Social Security. For example, under the National Health and Welfare Retirement Plan and under other private plans benefits may begin in a reduced amount at any time between age fifty-five and sixty-five, and they begin at age sixty-five even though one continues working.

The basis for calculating the Social Security old age benefit is the average monthly wage, in covered employment, from January 1, 1951, to actual retirement from work. A nurse who works intermittently in employment covered by Social Security may find that her wages, reported for the period of actual coverage, average out to only a part of the rate of salary she has been receiving. In that case her benefit is reduced to correspond with the overall average wage. Nurses who are approaching retirement age will be well advised to consult their local Social Security Administration office to make sure that they have enough "quarters of coverage" to qualify for old age benefits.

The foregoing four approaches to the problem of providing oneself with an income in old age are all important. If one has to choose it is best to come under Social Security and a plan with advantages similar to those of the National Health and Welfare Retirement Plan.* Personal annuities are excellent in addition, if you can afford them, but they usually put the burden of paying for them on the nurse. Every nurse, of course, should also have a savings account.

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* Inquiries may be addressed to the National Health and Welfare Retirement Association, 10 East 40 Street, New York 16.

Nursing Care of Patients with Advanced Cancer

ELISABETH H. BOEKER, R.N., and ROSALIE I. PETERSON, R.N.

UNTIL MORE knowledge is obtained regarding the cause of cancer, its diagnosis and treatment, and until present knowledge and facilities are used to the utmost, we will continue to have a large number of patients with advanced cancer. Present figures show that more than one half of the cancer cases diagnosed today have regional involvement or remote metastasis.[1]

The incidence of cancer is higher in the middle age and older age groups. Eighty-five percent of newly diagnosed cancer occurs in patients forty-five years of age or over, and 40 percent occurs in persons sixty-five years or over.[2] Studies have revealed that a high proportion of persons dying from cancer have also suffered from other diseases concurrently with the cancer. Chronic conditions associated with the aging process, such as cardiovascular renal diseases or diabetes, often accompany cancer in the older age group. In addition to physical illness, emotional and social problems peculiar to this age group may arise. These complicating factors should be considered in caring for the cancer patient.

Care of the cancer patient in the advanced age group may be made difficult by rigid behavior patterns which he has established through the years. The patient may find it difficult to accept his illness or the physician's recommendations when they run counter to his old way of life. He may voice his feelings toward a colostomy by saying that he would rather be dead than have such a thing done to him. The patient may be unprepared for the outcome of surgery; and the impact, when he realizes his changed bowel function, may make him reject his condition and rebel. Such attitudes retard recovery and hinder rehabilitation. The patient must accept his illness and want to live as normal and as useful a life as possible. The nurse has a real challenge in understanding the patient's needs and his reaction to his illness, in interpreting the disease to him, and teaching him nursing care.

In teaching nursing care to the student nurse we have stressed too often the physical aspects of the disease and ignored the emotional needs of the patient. Today we are becoming more aware of the influence of the mind and the emotions on physical wellbeing. This effect may be even greater under stress of illness. Through her direct service to the patient the nurse has many opportunities to discover the patient's problems. To reassure the patient and to teach him about his illness and his care are fully as important as the nursing procedures the nurse is administering, and certainly of more lasting value. The nurse views her patient as an individual reacting to his total environment. She recognizes any difficulties he might have in making emotional or social adjustments and gives supportive care as indicated.

Problems in Nursing Care

In considering nursing care per se of advanced cancer patients problems which readily come to mind are those associated with rehabilitation, nutrition, care of the skin, odors, and pain.

Rehabilitation

It may appear strange to consider rehabilitation of a patient with advanced cancer, but not when we realize that through presentday palliative measures much can be done to keep the advanced cancer patient free from pain and to give him a useful existence.

Miss Boeker is nursing consultant and Miss Peterson, chief, nursing section, Cancer Control Branch, National Cancer Institute, Public Health Service, Federal Security Agency.

By keeping the patient ambulatory as long as possible we postpone his days of invalidism. Being up and about is good for the morale of the patient; he is more hopeful, and the danger of his developing circulatory, respiratory, or orthopedic complications is decreased.

It is well to permit the patient to assume as much of the responsibility for his own care as possible. He should be encouraged to participate in activities, both mental and physical, according to his strength and ability. Contribution to the household through some useful duties can be a source of satisfaction to the patient. Irritability, depression, and boredom can be offset by developing diversional activities and maintaining contact with friends. Some patients even seek parttime employment. A specific job is good discipline and may through its absorbing and timeconsuming nature prevent the patient from becoming demanding and critical. The patient is more content if he believes that he is contributing his share to everyday living.

Nutrition

Cancer patients frequently suffer from anemia, loss of weight, poor nutrition, and avitaminosis. To combat these conditions the patient requires a high protein diet rich in calories and vitamins. Proteins are of particular importance in aiding the healing process, in restoring depleted and broken down tissues, and in combating anemia. The problem of feeding the cancer patient is often increased by his lack of appetite. Serving attractive well prepared food in small amounts is important. Resourcefulness is needed to interest the patient in taking food and to modify the diet to suit his likes and dislikes.

When the gastrointestinal tract is involved there may be interference with swallowing, digestion, assimilation, or even metabolism of food. If a regular diet cannot be tolerated soft bland foods may be substituted, or smaller more frequent feedings of easily digested and assimilated foods may be given.

If the lesion is located in the esophagus and the patient has difficulty in swallowing, or if tube feedings become necessary, all of the essential food elements can be given in a liquid or semiliquid form. Special formulae may be used or vegetables, fruits, or meats can be liquidized by means of a food mill or blender. Baby foods may be used at home, or foods can be made the right consistency by using a food strainer, ricer, et cetera.

When the disease involves the stomach and proteins cannot be digested because of the limited amount of hydrochloric acid produced, hydrolyzed proteins in the form of amino acids can be given. If liver function is impaired and bile is not secreted in sufficient amounts, fats must be reduced. As the disease progresses the patient's food intake may become so limited that subcutaneous and intravenous fluids or blood transfusions may have to be given.

Care of the skin

When the disease reaches the stage at which the patient is confined to his bed for a long period of time, care of the skin can become a problem. The basic principles of preventing decubiti must be applied. The skin must be kept clean and dry and free from irritation or pressure. Circulation can be maintained through massage and change of position. Alcohol will help toughen the skin and creams or oils can be used to prevent cracking or chafing. The alert nurse recognizes early effects of pressure and directs her efforts toward preventing a breakdown of tissue.

Odors

Contrary to common belief ulcerating lesions with drainage are not the inevitable result of cancer. More than half of all cancer patients never develop open lesions with odors.[3] Cancer itself has no odor, but when necrosis develops or infection invades the lesion, offensive odors result. Cancerous lesions are highly susceptible to infection because of the presence of necrotic tissue, poor blood supply, inadequate drainage, or effects of radiation. Contamination of the lesion can occur from dirty hands or soiled clothing.

If ulcerous areas develop odors can be reduced to a minimum by frequent changing of dressings, removal of necrotic tissue, irrigations, or wet dressings. Keeping the patient and his wounds clean and free from infection is of paramount importance in controlling offensive odors. The use of sulfonamides and

antibiotics has done much to reduce secondary infections.

When odors occur there are various methods of combating them in the immediate environment of the patient.[4] Proper ventilation is one simple means of diluting odors and good sanitation with the use of soap and water is another effective means. Antiseptics reduce odors caused by bacteria, molds, or fungi, and chemical substances and oxidizing agents react with odorous materials to form new compounds which are odorless. Reodorization through the use of perfumes or essential oils merely masks odors by substituting others. Light concentrations of such substances as formaldehyde or ozone in the air will reduce the sense of smell by desensitizing or anesthetizing the olfactory nerve. Common odorous vapors can be adsorbed by activated carbon.

To reduce odors in the lesion itself, zinc peroxide may be applied directly to the wound or dressings kept moist with a thin paste may be placed over the lesion. The moist zinc peroxide releases oxygen slowly and inhibits the growth of bacteria, especially the anaerobes. Dressings moistened with lactose solution or granulated sugar sprinkled into an ulcerating lesion changes the flora and reduces odors caused by bacterial proteolysis. In a similar manner urea which has bactericidal properties may be dusted on wounds or saturated dressings may be applied to deodorize and to promote epithelization.

Patients are sensitive to unpleasant odors and every effort should be made to keep odors at a minimum. If odors can be controlled there is no reason why cancer patients should be isolated or why they cannot be cared for in facilities with other sick patients. Within limits the patient can be taught to care for his own needs and can assume responsibility for dressings and irrigations. Good personal hygiene and clean lesions are basic to the control of odors.

Pain

Pain is a late symptom of cancer and may be caused by ulceration with secondary infection, pressure on or direct involvement of nerves or bones, obstruction of hollow viscera, or invasion of an organ by cancer.[5]

Good medical and nursing care can do a great deal to keep the patient comfortable and control pain. With presentday methods of palliation through surgery, radiation, or chemotherapy the patient is spared much pain and discomfort. For direct relief of intractable pain injections of alcohol into nerves, and in extreme cases such surgical procedures as chordotomies or lobectomies, can be done. Large and frequent doses of narcotics are becoming less necessary with good medical and nursing care.

A nurse carried out an experiment in a seventy-five-bed ward to determine whether extra nursing care would reduce the need for sedation.[6] Over a period of a month she found that on nights when she gave more time to her patients, building up pleasant human relationships and doing little things for them, the requests for sedatives were reduced 33 percent. When in addition to this "extra" nursing care the physician visited the patients for an hour, the calls for sedatives were reduced 45 percent. On evenings when essential nursing duties were completed, but extra nursing care and the physician's visit had to be omitted because of the pressure of work, the requests for narcotics returned to approximately the same level as before the experiment.

Because cancer may be a longterm illness it is wise to withhold the use of narcotics until other drugs have proved to be no longer effective. A distinction should be made between drugs given for analgesic effects and those given for hypnotic purposes. Sleep at night is a prerequisite for cancer patients and sedatives are generally given freely. Bromides, sodium amytal, and barbiturates are drugs of choice to produce sleep. Aspirin has been found useful in relieving mild bone pain and in giving relief from pain resulting from glandular metastasis, and in addition it is a mild hypnotic. When the lesser drugs are no longer effective codeine alone or in combination with aspirin may be given.[7]

When morphine or opium derivatives must be resorted to for the good of the patient, only enough of the drug to relieve pain should be given. If possible it is well to avoid establishing a regular schedule for giving narcotics so that the patient will not wait in expectation

for his next dose. If pain is severe and continuous better results are obtained when the effects of the narcotic are not permitted to disappear completely before giving the next dose. As the disease progresses and more frequent and larger amounts of narcotics are needed the nurse must be alert for signs of addiction such as itching, nausea, vomiting, constipation, or euphoria. Dosage should not be increased faster than the disease develops.

A resourceful nurse will use all possible means at her disposal before resorting to the use of narcotics. The patient who is made comfortable and kept busy and interested in activities, both mental and physical, within his limitations, is much more satisfied and is less apt to dwell upon his discomfort.

Terminal Care

From a survey of terminal care of cancer patients in the Chicago area we learn that the average length of time the cancer patient requires terminal care is ninety-three days. It has been estimated that at any time about two thirds of all cancer patients needing terminal care will be in their homes and one third in hospitals and related institutions.[8] From these facts we realize that the family is assuming a good portion of patient care. Even when hospital facilities are adequate patients often prefer to remain in their homes for care or to reduce the financial burden to their families. Because cancer patients are in and out of the hospital it is important that a close relationship be maintained among physician, nurse, patient, and family.

The nurse, in the hospital and in the home, can be of great assistance in preparing the family for care of the patient. The nurse who is aware of the attitudes of the patient and his family toward the illness and their understanding of related problems can help them to adjust to their situation. The nurse can teach and supervise nursing care procedures adapted to home facilities, acquaint the family with available community resources, interpret the physician's orders and the patient's condition and needs. A responsible member of the family should know the extent of the disease and the prognosis. He should know what to expect, the manner in which the disease spreads, the signs of such complications as metastasis, hemorrhage, or pathological fracture. Members of the family are better prepared to care for the patient if they know what may develop and what can be done. The nurse can give support to the family in facing these many problems. She can encourage them to express their fears and anxieties and direct their thoughts and emotions into constructive action.

There comes a time when the patient and his family must face the approach of death. The manner in which they accept this fact will depend upon their emotional, social, and religious backgrounds. To help the family the nurse must have a confident courageous philosophy of life and death and know when to direct them toward spiritual help.

Today we are doing more for the cancer patient than ever before. With the early discovery of cancer and the prompt effective treatment of the disease, we are offering the cancer patient hope. Even with advanced disease the patient can be greatly helped. As our knowledge of cancer progresses we may look forward to the day when the early curable cancer cases we encounter will outnumber those in the far advanced stages.

REFERENCES

1. These data are based on morbidity surveys in five metropolitan areas: Atlanta, New Orleans, Denver, San Francisco, and Pittsburgh. The surveys were conducted by the National Cancer Institute in 1948.

2. *Ibid.*

3. The Central Service for the Chronically Ill of the Institute of Medicine of Chicago. *Terminal Care for Cancer Patients.* Chicago, The Central Service for the Chronically Ill of the Institute of Medicine of Chicago, 1950. p. 3.

4. Hospital Bureau of Standards and Supplies, Inc. *The Problem of Odors in Institutions.* 247 Park Avenue, New York 17, Hospital Bureau of Standards and Supplies, Inc., 1947.

5. Daland, Ernest M. The relief of pain in cancer patients. Supplement No. 121 to the *Public Health Reports,* 1936. Washington 25, D.C., U. S. Government Printing Office.

6. Schwartz, Doris R. Nursing care can be measured. *American Journal of Nursing,* March 1948, v. 48, p. 149.

7. Daland, *op. cit.*

8. The Central Service for the Chronically Ill of the Institute of Medicine of Chicago, *op. cit.,* p. 2.

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ABSTRACTS . . .

IRAN MARCHES AGAINST MALARIA

In Iran today infant mortality is from 25 to 50 percent of all live births. Some mothers do not see one child grow to adulthood, and it is not uncommon to find people suffering from two or three major illnesses. The ordinary man accepts this as he accepts poverty with the avowal that "Allah wills it."

But there are some peasants who are not so certain about the inevitability of sickness. They have seen groups of people traveling from village to village, spraying houses and sheds with DDT. And they saw that when the next malaria season came there were not so many sick people to be cared for and fewer babies died. When the next year came and there was no repetition of the spraying in some parts of the country thousands of letters from peasants were sent to government officials and to Tehran, written by the public scribes and signed with fingerprints. Their message was "We want more malaria action."

DDT creates dramatic action, is easy to apply, and is cheap. Once the curiosity and interest of the peasant are aroused by the spraying the public health nurse can go into the village and tell the story of the malaria parasite and take a smear of blood without arousing fear. Malaria control work is also an ideal starting point for a health campaign.

In 1949 two WHO staff members visited the town of Chalus and found that 89 percent of the school children had malaria. The next spring, after a demonstration spraying had been done, the figure had dropped to 50 percent. This year only 21 percent of the children had enlarged spleens, the accepted gauge of infection, and most of the youngest ones were untouched by malaria, having been born since the first spraying. Everywhere reductions averaging 50 percent have been observed after one or two seasons of spraying.

The World Health Organization has been called in on an advisory basis by the Ministry of Health to help with planning the malaria control program and the training of young men to insure the continuation of the program. It is estimated that it will take five years to bring malaria under control in Iran if this good beginning is continued.

From WHO *Newsletter*, January 1952.

HIGHER EDUCATION AND THE PROBLEMS OF THIS DECADE

Higher education can be an instrument for meeting some of the problems of our society in this so-called defense decade. The new role of higher education, from the point of view of society, is that of a leader and yet a servant of society. To assume that position higher education must possess a vigor and a healthy-mindedness that will enable it to make its contributions to the solution of many of the problems of this decade. For example, it must dismiss the sense of futility which pervades the thinking of so many men and women today.

Some basic assumptions should be accepted: that we can profit from the mistakes as well as from the successes of the past, that the rights of the ordinary man are to be protected, that the mind and will of man are more powerful than all other forces in the world, that unmitigated speed is not so effective as the slow and tedious process of human thought, that science is a neutral factor and that it can be used for the upbuilding of civilization, that man's organizational ability to get things done can be turned in the direction of the orderly development of man's life on earth rather than being used for the destruction of our world, and that permanent peace is obtainable.

In contributing to the betterment of man higher education should perform certain func-

tions in addition to those which are naturally associated with higher education. In other words, it must not divorce itself completely from the old traditional patterns of service, but should enter new areas of attention in keeping with modern demands. The primary function is to redefine what is meant by a desirable civilization. Since there are conflicting ideas about that ideal and definitions of it it is understandable that social tensions spring up among groups of people.

With these tensions comes emotionalism. This is apparent in the mass hysteria of our times. It is mass hysteria which makes it almost impossible for anyone to think honestly or to speak frankly for fear of being branded radical or subversive. Higher education must use its weapons, scholarship and enlightenment, to help abolish these fears.

Higher education must define not only good government but also good statesmanship as a means of developing and maintaining good government. It must encourage the development of a government which inspires statesmanship and not political expediency.

The practical objectives of a good civilization fall into three categories—those having to do with international relations, those having to do with internal relations in a democratic society, and those having to do with human nature and human personality. In the broadest field, that of international relations, the job of higher education is to better relations with other countries. For example, there is a great need to restore the friendship between Asia and the United States. Asia now considers us to be an imperialistic nation. The average American does not like imperialism, and our government and education should more clearly express the actual feeling of its people. Higher education should try to find new ways of dealing with the peoples of Asia and other nations to reach an understanding.

In addition to studying and defining the roles of government and politics higher education must study the true functions of other areas of activity. Science and engineering have as their real function the job of making the world a better and a happier place in which to live. A vocation can no longer be considered as an end in itself, but as a means of contributing to mankind. The relationship of the social sciences to other services performed by leaders of our society must also be studied. So must the question of the moral, ethical, and spiritual disintegration of society, which involves studying the problems of criminology and the lack of religious education today. These problems must be approached on a large scale by all of the forces of higher education in the country, not just by attempting to eradicate the problems by teaching short introductory courses on individual subjects. In addition to studying those problems higher education should give more attention to the arts and to the finer expressions of the human mind and the human soul. The mind must be conditioned to love the finer things in life.

If higher education is to play its part in solving the problems of this decade it must also enter into the field of mental health, thereby starting from the smallest category, that having to do with human nature and personality, and working into the larger ones —those involving national and international relationships.

The first step towards handling the problems which now beset mankind is to understand the problems. Then students and teachers throughout the world must join together to develop ways to meet these problems. And higher education must join with government and leaders in society in the common task of creating and defending a desirable civilization.

From "Higher Education and the Problems of This Decade" by J. Hillis Miller in *The Educational Record*, October 1951.

SEROLOGY PROBLEMS

In nursing, as in other professional fields of health, the phenomenon of serologic false-positive reactions is of great interest. The abstract of the study reported here of the high incidence of presumably false-positive reactions in Central America indicates that conditions may exist in different geographic areas which do not lend themselves to the adoption of procedures which may be the prevailing practice in the United States.

Syphilis serology in Central America presents a special problem because of the fact that certain test methods which have proved reliable in the United States give a high percentage of positive reactions apparently as a result of conditions other than syphilis. There is a marked difference in reactivity of the older tests using lipoidal antigens, such as the Kahn, Mazzini, and Eagle, and the newer tests using cardiolipin antigens.

In 1946 the Pan American Sanitary Bureau, with assistance from the USPHS, established a venereal disease research laboratory in Guatemala for the purpose of conducting an investigation of the serologic picture presented by the people of that area. In order to evaluate the difference in test reactivities studies were conducted among children where the incidence of acquired syphilis is low. Children from an orphanage in Guatemala City and from a school in the Port of San Jose, Guatemala, an endemic malaria area, were selected. Only 5 of the 666 children tested were thought to have congenital syphilis. About 65 percent of the children gave negative results with the Kahn and Mazzini tests, while about 95 percent gave negative results with the VDRL and simplified Kolmer tests.

Studies were carried out in other countries of Central America in order to determine if a pattern of reactivity similar to that found in Guatemala existed in them. Results in Panama were similar to those in the United States and differed from those obtained in the rest of Central America. The general trend is for the tests using cardiolipin antigens to have a higher percentage of negative results than those using lipoidal antigens.

From "Serology Problems (Syphilis) in Central America" by Genevieve W. Stout and John C. Cutler in *Journal of Venereal Disease Information*, September 1951.

GROUP PSYCHOTHERAPEUTIC APPROACH

Development of a child's personality is determined largely by the ways he is handled by his mother. Her handling is based both upon her factual knowledge of child care and development and upon her emotional attitude toward him. The staff of the Lasker Mental Hygiene and Child Guidance Center in Jerusalem has set up a program using individual and group technics to modify the mother's emotional attitude to her child.

Because during pregnancy the foundations are laid for the mother's future relationship with her child, and disturbing tensions may begin at this time, a group of pregnant women, attending the antepartal clinic regularly, was chosen for the project. Experience has shown that people in groups are willing to speak more readily about intimate and private feelings than when they are alone with a therapist —probably because they feel protected in their relationship with him by the presence of supporters in the other group members. A surprising discovery in group psychotherapy has been the readiness with which people will discuss their secret thoughts with strangers.

The psychiatrist gives a lecture to the clinic group once a month. Three psychiatric social workers assist in this program. The clinic nurse is present at these sessions but plays a passive part in this particular program. She has a separate lecture period with groups in the clinic. There is no special way of choosing the patients; all the women who happen to be present on the day of the lecture are invited to attend and the majority accept. There is no distinction made between women in their first pregnancy and those who have been pregnant before; the women may be in all stages of pregnancy. The mothers come from many different culture patterns and countries. Their economic statuses, occupations, and educational backgrounds are completely varied also. Most of the women attend five or six lectures.

Every detail of these meetings has been thought out most carefully. Not only seating arrangements (to avoid a formal atmosphere) but all the different points of the lectures are stereotyped. And although each lecturer impresses his own personality upon his handling of situations that develop an attempt is made through joint planning to work out a uniform approach.

One of the chief early objectives is to stimulate a reassuring and permissive atmosphere

in which the women will feel free to discuss their fears and doubts and feelings of guilt and shame with the conviction that they will be understood and not condemned. This is achieved not only by the careful choice of subject matter but also by the way it is treated and by the studied avoidance of an authoritarian or didactic tone, also by the use of words that are on an emotional rather than intellectual plane.

The lecturer selects topics which he knows are related to probable sources of worry, shame, or guilt in pregnant mothers and which will stimulate fruitful discussion. As the lecturer talks he observes the women and emphasizes or enlarges on any point that he notices has a special appeal to a number of the group. In the discussion period the mother is reassured by relieving her anxieties. The psychiatrist uses the technics of suggestion and of introducing an important topic as an aside. This helps the mother accept knowledge and obtain reassurance with the arousal of little resistance. Another function of the lectures is to forewarn the mothers about future anxieties and difficulties, thus reassuring them in advance.

At the end of the lecture the audience is invited to start the discussion period by asking questions. The most fruitful discussions result in groups of from ten to twenty women. The lecturer refers back to the group many of the topics. In the lecture his main technic is suggestion; in the discussion his role is interpretive. He points out evidences of anxiety and guilt and in the main leaves it to the group to try to reassure each other. The women gain their greatest assurance from hearing one another talk. An interesting discovery has been that differences in culture do not interfere with full participation.

From "Mental-Hygiene Work with Expectant Mothers—A Group Psychotherapeutic Approach" by Gerald Caplan, M.D., in *Mental Hygiene*, January 1951.

ABOUT PEOPLE YOU KNOW

The Community Health Association of New Orleans has announced the appointment of *Antoinette Bevilacqua* as nursing director. . . . *Mary Harrigan* and *A. Mabelle Hirsch* have retired from the Nursing Bureau of the Metropolitan Life Insurance Company, Miss Hirsch to accept a position as nursing consultant with the United Mine Workers Welfare and Retirement Fund in Birmingham, Alabama. . . . *Zella Bryant*, chief nurse, Division of Chronic Disease and Tuberculosis, United States Public Health Service, is one of the consultants to the communicable disease workshop being held in Lima, Peru, June 30-August 8.

Eliza C. Avellar and *Gertrude L. Craddock* joined the staff of the California State Department of Public Health, Miss Avellar as maternity hospital nursing consultant in the central part of the state and Miss Craddock as mental health nursing consultant, working on a statewide basis. . . . Veterans Administration has made the following transfers and assignment: *Regina T. Kelley*, from the Wilkes-Barre (Pennsylvania) regional office to the Houston (Texas) regional office as chief, nursing unit; *Emily M. Elder*, from Scranton (Pennsylvania) to Wilkes-Barre as chief, nursing unit; *Lucile V. Lukens*, formerly public health nursing consultant, Oregon State Board of Health, as chief of the nursing unit.

NOPHN delegates to the National Health Council are *Alma Haupt*, *Mrs. H. Stanley Johnson*, and *Mrs. Grayson M. P. Murphy, Jr.* . . . *Ethel Phillips*, director of the Chemung County Visiting Nursing and Tuberculosis Association (New York) for twenty-two years, retired on June 1. . . . *Lois B. Goodman* has been appointed director of nursing services for the Pacific area, American Red Cross, succeeding *Irene Thompson*, who resigned to become director of public health nursing, Portland, Oregon. Miss Goodman has been with the Red Cross since 1941. . . . *Virginia M. Dunbar*, formerly dean of Cornell University-New York Hospital School of Nursing and director of the New York Hospital Nursing Service, is now devoting her full time to the nursing school. *Muriel R. Carbery*, formerly associate director of the nursing service, is now director. Faculty of the school and staff members of the nursing service continue to hold joint appointments with the university and hospital,

Dr. G. Halsey Hunt, formerly chief of the Division of Hospitals, Public Health Service, Federal Security Agency, has been appointed an assistant surgeon general and will serve as associate chief of the Bureau of Medical Services. . . . *Judith Gage Whitaker*, formerly executive secretary of the Nebraska SNA and for the last two years parttime assistant executive director of the ANA, is now associate executive secretary of ANA. Her duties will include coordinating ANA sections, directing the orientation program for snas and ANA staff members, and coordinating ANA staff field work.

NEW BOOKS
And Other Publications

HEALTH INSURANCE PLANS IN THE UNITED STATES

Report of the Committee on Labor and Public Welfare, United States Senate. Senate Report 359, in three parts. May be secured from the United States Government Printing Office, Washington 25, D.C. 1951. Part 1, 114 p., 30c; Part 2, 197 p., 45c; Part 3, 44 p., 15c.

This study of health insurance coverage in the United States is the most comprehensive now available. Part 1 includes data on the number of persons having medical care insurance, the benefits available, insurance costs, a comparison of medical costs and insurance protection, and medical care insurance among the industrial, rural, and aged populations. Some of the findings of the study are as follows: 75,000,000 people have protection against some part of the costs of medical care, but only 3,000,000 to 4,000,000 have comprehensive medical care insurance including hospital, surgical, and medical (nonsurgical) coverage; about half of those having hospital insurance were insured through the Blue Cross plans and about 34,000,000 held policies issued by insurance companies; 18,000,000 who have surgical and medical policies are covered by Blue Shield and 30,000,000 by the insurance companies; persons living in industrial urban areas and in states with high per capita income are more likely to have medical care insurance than those in rural areas and in low income states.

Part 2 consists of statements from the Blue Cross and Blue Shield Commissions, the Cooperative Health Federation of America, the insurance companies, the Social Security Administration, and the American Medical Association. These statements provide, in large part, the information utilized by the staff that prepared the report. They give detailed information and some of the philosophy of the various groups regarding medical care insurance.

Part 3 summarizes the medical care and health activities of government on the federal, state, and local levels.

—HELEN CONNORS, R.N., *Secretary,* ANA-NOPHN *Committee on Nursing in Medical Care Plans.*

RURAL HEALTH AND SOCIAL POLICY

Elin L. Anderson. Privately published, 18 Williams Lane, Chevy Chase 15, Maryland, Michael M. Davis. 1952. 31 p. 50c.

This book is a memorial to Elin Anderson who died in the prime of her life on January 4, 1951. Members of NOPHN will remember that she was a member of the board from 1948 until her death. The book contains excerpts from addresses given at a memorial meeting held for her in Washington and selections from her own writings. It is a small book but a great tribute.

It was the hope of many of Elin's friends that she would write a book on rural health work. Death claimed her too soon. We are deeply indebted to the authors and friends for this digest of her philosophy of rural health work. We believe the book will be helpful to others who are striving to build a better social order and thus it will be a living memorial to

Elin. It will be an inspiration to those who with her believe that "whether we are striving for the sake of greater economic justice or in the name of the religion of love which we all profess, our goal is the same—the building of a social order in which poverty, disease, and the accompanying ills shall be no more. Can we not unite in this great and common enterprise?"

Those who spoke at her memorial service gave us a little idea of how Elin's associates felt about her. In the words of Michael M. Davis, "Elin Anderson combined three qualities, any one of which would render a human being distinctive. Brought together in one human being, they created a leader. She possessed intelligence, whereby she could understand the elements as well as the outlines of complex problems. She possessed conscience, so that understanding was futile to her unless followed by accomplishment. Her pursuit of her objectives was therefore unswerving. She possessed faith—faith in people. Intelligence gave her power to plan, conscience, power to work, faith, power of leadership."

—DOROTHY RUSBY, R.N., *Assistant Director*, NOPHN.

PHYSICAL REHABILITATION FOR DAILY LIVING

Edith Buchwald, M.A., P.T., in collaboration with Howard A. Rusk, M.D., George G. Deaver, M.D., and Donald A. Covalt, M.D. New York, McGraw-Hill Book Company, Inc. 1952. 183 p. $7.50.

Designed primarily as an aid in the activities of daily living—walking, eating, dressing—this well illustrated book will be of most help to trained and prepared personnel.

These technics, previously developed by Dr. George G. Deaver and Mary Eleanor Brown and Marjorie P. Sheldon, physical therapists, are illustrated by excellent photographs.

The hospital nurse, the public health nurse, the physical therapist, and the occupational therapist will find this book a useful source of information as a refresher on past developments and as a guide to new additions and modifications of rehabilitation.

Each analysis of activity is in outline form, is concise and to the point. The material is presented in a readable and practical manner. There is a brief but comprehensive index, and the format is excellent.

—FRANCES E. GOODMAN, R.N., *Orthopedic Consultant*, JONAS.

THE COST OF SICKNESS AND THE PRICE OF HEALTH

C.-E. A. Winslow, Dr. P. H. New York, Columbia University Press. 1951. 106 p. $1.50.

Discussions at the Fifth World Health Assembly will center on the economic value of preventive medicine. This monograph was prepared as a basis for the discussions. Written in Dr. Winslow's usual interesting and inimitable style it presents factually and concisely global problems of public health and preventive medicine, the success achieved by some countries in eliminating or controlling certain diseases, and an enumeration of existing programs directed at continued efforts to achieve better health on a global basis.

The cost of sickness, methods of reducing the burden of disease and the economic results attained, planning a national health program and its cost, the interrelationships of poverty and disease, and the program of technical assistance constitute the major areas discussed in this monograph.

Citing the fact that a united world cannot be built with constituent nations handicapped by overwhelming burdens of poverty and disease the author recommends that a public health program adapted to an individual nation's needs offers the most economical method of breaking the chains of disease and poverty. To accomplish these objectives, it is suggested, first, that an analysis be made by each country of the most important health problems that can be attacked with maximum results and minimum costs; and, second, that the development of programs of cooperative technical assistance be continued.

In presenting the relation between poverty and disease China, Egypt, and India are cited as countries in which the average life expectancy at birth is approximately thirty years. In these three countries only 50 percent of the children born reach the age of fifteen and enter the period of maximum economic productivity.

Dr. R. G. Padua, under-secretary of health

of the Philippine Islands, is quoted as stating that his country with a population of 20,000,000 people has 10,000 deaths annually from malaria and 35,000 from tuberculosis. These statistics and others from around the world emphasize the tremendous unsolved health problems in the less well developed areas and the human and economic losses resulting from such conditions.

A review is given of the achievements in environmental sanitation and contagious diseases and of future possibilities in those fields. Again, one is impressed with the wide differences in the application of available knowledge in the well developed countries contrasted with that of the less well developed countries. The fact is further emphasized that health and economics run hand in hand.

A chapter on the interrelationships of poverty and disease is most interesting and well authenticated. The question, Are public health workers doing more harm than good by reducing death rates while birth rates maintain —or increase—their present level, is answered.

The author emphasizes that the technical assistance program is neither a relief project nor a visionary means of imposing upon primitive peoples an alien way of life. On the contrary, with possibilities of improvement in global economy as a result, it is a practical method of providing leadership and of helping people to help themselves.

In reading this monograph one is made acutely aware of the serious and widespread unsolved public health problems in many areas of the world, the very definite relationship of social, cultural, and economic progress with health, and the necessity—if one has a concept of One World—of the well developed areas providing leadership, technical assistance, and financial aid to the less well developed countries.

The monograph is interesting, informative, thought-provoking, and well worth reading.

—L. E. BURNEY, M.D., *State Health Commissioner, Indiana State Board of Health.*

SOCIAL WORK

SELECTED PAPERS IN CASEWORK. National Conference of Social Work. Raleigh, Health Publications Institute, Inc. 1951. 176 p. $1.75. A collection of twenty-one of the papers presented at the 1951 annual meeting of the National Conference of Social Work. These papers were chosen on the basis of being of broad and general interest. A few of the titles are Education for Responsible Parenthood, Meeting the Mental Health Needs of Children in School Today: Psychiatric Implications for the Practice of School Social Work, Maximum Use of Casework Service in a Period of Mobilization, Homemaker Service as a Method of Serving Children, Constructive Aspects of Public Assistance for Children, The Use of Foster Homes in the Care of Unmarried Mothers.

SELECTED PAPERS IN GROUP WORK AND COMMUNITY ORGANIZATION. National Conference of Social Work. Raleigh, Health Publications Institute, Inc. 1951. 144 p. $1.75. A collection of twenty papers presented at the 1951 annual meeting of the National Conference of Social Work. The papers are specific and concrete and contain new and significant data of practical value to both the administrator and the practitioner involved in group work and community organization. Some of the titles are Applying New Knowledge About Group Behavior, Similarities and Differences Between Group Work and Group Therapy, How Can We Interpret Group Work to the Public in These Times, Special Needs of Congested Communities.

GENERAL

THE LAMP IS LIT. Ritchie Calder. World Health Organization Division of Public Information. 1951. 40 p. 25c. In this booklet words and photographs tell the dramatic story of some of the activities of WHO in its worldwide program to provide good health for all peoples. Copies may be obtained from the Office of Public Information, Pan American Sanitary Bureau, Regional Office of World Health Organization, 1501 New Hampshire Avenue, N. W., Washington 6, D.C.

Three publications of The National Conference of Christians and Jews, Inc., New York. 1952. 25c each.

FEELINGS ARE FACTS. Margaret M. Heaton. 59 p.

THE RESOLUTION OF INTERGROUP TENSIONS. Gordon W. Allport. 49 p.

READINGS IN INTERGROUP RELATIONS. Helen F. Storen. 39 p.

POLITICS IS WHAT YOU MAKE IT. Joseph E. McLean. New York, Public Affairs Committee, Inc. 1952. 31 p. 25c; special quantity rates.

WOMEN IN THE DEFENSE DECADE. Raymond F. Howes, editor. Washington, D.C., American Council on Education. 1952. 110 p. $1.25.

(Continued on page A13)

NEWS AND VIEWS

FROM HEADQUARTERS

Sheila M. Dwyer joined the NLN staff on July 1 as consultant in nursing education in the Tuberculosis Advisory Nursing Service. Miss Dwyer recently was an instructor at Teachers College, Columbia University, and also special consultant to the Division of Chronic Disease and Tuberculosis, USPHS. She is a graduate of Mount St. Mary's Hospital School of Nursing, Niagara Falls, New York, and holds B.S. and M.A. degrees from Teachers College, Columbia University.

Miss Dwyer has been head nurse and supervisor, Presbyterian Hospital, New York; instructor, College of Physicians and Surgeons, Columbia University; director of nurses, Southampton Hospital, New York; assistant professor of medical-surgical nursing, Niagara University, Niagara Falls, New York; educational director, Niagara Sanatorium, Lockport, New York. She is the author of Undergraduate Nursing Education to Meet the Needs of the Tuberculous published in the 1950 *Transactions* of the NTA.

ORTHOPEDIC NURSING SCHOLARSHIPS

The National League for Nursing is administering the Carmelita Calderwood Hearst scholarship, established in memory of Mrs. Hearst, who was the NLNE consultant on the JONAS staff from 1941 to 1944. The fund was set up by her husband. This scholarship is available to registered nurses who wish to prepare themselves for teaching orthopedic nursing and who have shown an interest in and fitness for that field. Many of Mrs. Hearst's friends have said they wish to add to the fund, thus increasing the number of scholarships. The NLN will receive such contributions and will send further information about the fund upon request. Write to the Carmelita Calderwood Hearst Fund, care of NLN, 2 Park Avenue, New York 16.

REPRINTS AVAILABLE

The following reprints from the magazine are now available: United Community Defense Services Program, by Eva M. Reese, from the April issue, *free*; A Small Official Agency Studies Public Health Nursing Costs, by Sybil P. Bellos, from the May issue, 15 cents; Cars for Public Health Nurses, containing six reprints and preprints from the February through July issues, 25 cents.

One copy of each of the above reprints may be secured free by NOPHN *members.*

MARY M. ROBERTS AWARD

A public health nurse, Anne Rice, is the winner of the 1952 Mary M. Roberts Fellowship Award. The Award Committee of the American Journal of Nursing Company selected Miss Rice's manuscript, Geriatrics and I, as the outstanding article submitted. Miss Rice is supervisor of public health nursing, Baltimore County Health Department. She is a graduate of Washington University School of Nursing, St. Louis, Missouri, and has a master's degree from Columbia University. Miss Rice will study journalism at Columbia University under the fellowship grant.

EDUCATION OF PARTIALLY SEEING CHILDREN

The Committee on Education of Partially Seeing Children, a standing committee of The National Society for the Prevention of Blindness, met in October 1951 to review overall policies and programs, and to make recommendations about future plans and action. The official report, reprinted from *The Sight-Saving Review*, volume 22, number 1, may be obtained from NSPB, 1790 Broadway, New York 19. Price 5 cents.

The report reviews the history of classes in America for partially seeing children and discusses the four patterns of such education—

placement in schools for the blind; placement in special schools with other handicapped children; placement in segregated classes in the public schools; and cooperative placement plans—that is, enrollment in a special sight-saving class in which all close eye work is done; the child leaves this class several times a day to join normally seeing classmates in activities not requiring continued use of the eyes. However, because many modern schools embody sight-saving principles the visually handicapped child has less need than formerly for the special classroom, and enrollment in special classes is steadily decreasing.

The committee therefore recommends the establishment of cooperative facilities in preference to any of the other three patterns of educating partially seeing children.

PAMPHLETS ON HANDICAPPED CHILDREN

Two new pamphlets for parents of handicapped children—The Child Who Is Hard of Hearing and The Child with Epilepsy—are available from the Children's Bureau, Federal Security Agency. These are part of a series by CB on handicapping conditions of childhood. The first of the series, The Child with Cerebral Palsy, was issued earlier.

The epilepsy pamphlet describes the condition, outlines the kind of care such handicapped children need, points out that they need not be segregated if their condition is understood and controlled, and gives commonsense suggestions about such practical matters as looking for a job. The pamphlet on the child who is hard of hearing includes hints on how to help such children.

Write to the Superintendent of Documents, U. S. Government Printing Office, Washington 25, D. C., for each pamphlet. Price 5 cents a copy.

FULBRIGHT AWARD APPLICATIONS

The Committee on International Exchange of Persons, Conference Board of Associated Research Councils, announces that it is ready to receive applications for 1953-1954 Fulbright awards for university lecturing and advanced (postdoctoral level) research in Europe and the Near East. Closing date for making application is October 15, 1952. Application forms and additional information obtainable from the committee, 2101 Constitution Avenue, Washington 25, D. C.

EATING IS FUN

The American Dietetic Association announces the availability of a booklet, Eating is Fun, for the guidance of persons operating small nursing homes and homes for the aging. There is practical information on menu patterns based on the normal nutritional requirements for older people, including suggestions on menu planning, sample daily meal plans, with special emphasis on sample suppers, apparently the hardest meals to plan. The booklet also contains tips on saving money, on the weekly marketing plan, as well as a discussion of the dining room plan compared with tray service and an outline of general principles of cookery and kitchen equipment.

Write to ADA, 620 North Michigan Avenue, Chicago 11, for a copy. Price 50 cents; discount on quantity orders.

PATIENTS IN MENTAL HOSPITALS

The National Association for Mental Health recently released a report of the investigation of the extent of mental illness, the adequacy of facilities for treating it, and the cost to the people of this country.

The report discloses that the number of patients suffering from a variety of mental illnesses in mental hospitals throughout the country has been increasing steadily every year; that there has been an increase of about 20 percent since 1940. The 650,000 patients in mental hospitals today are as many as there are in all other hospitals combined.

Admissions of new patients have risen to 250,000 annually and readmissions amount to about 100,000 a year. Schizophrenia is a major problem, accounting for the bulk of the patients in mental hospitals, the reason being that schizophrenic patients who are not discharged stay in hospitals for years.

However, the association says this does not mean that mental illness is increasing. Some of the increase may be attributed to the rise in the number of hospitals and the fact that

people are less afraid and ashamed today to make use of mental hospitals because they recognize that such hospitals are becoming medical institutions for treatment rather than asylums for custodial care. The growth in population and the increased lifespan are other factors. More old people are alive today than there were in 1940, and the incidence of mental illness has always been high in the older age brackets.

The association found that there are about 680 mental hospitals in the United States; that about 97 percent of the mental hospital beds are in public hospitals—federal, state, county, city; that state hospitals contain 82 percent of all the mental hospital beds. Conditions in most of the state hospitals are unsatisfactory; overcrowding, understaffing, and inadequate use of known treatment methods are widespread. None of the state hospitals meets American Psychiatric Association standards for minimum personnel; they are dangerously understaffed in all categories of personnel—physicians, registered nurses, psychiatric social workers, hospital attendants. There is overcrowding in three out of every four state hospitals, in excess of 30 percent in nearly a third. In addition, most of the beds in these hospitals are "unacceptable" in terms of federal health and safety standards. A good index of the kind of care and treatment received by patients is the amount spent per patient on hospital maintenance costs. The amount spent daily in state mental hospitals is a little more than $2, compared with $7 in veterans mental hospitals and $9 to $11 in private mental hospitals.

Nearly a half billion dollars were spent by federal and state governments in 1951 on the operating costs of federal and state mental hospitals. Most of the federal expenditure was for veterans mental hospitals. Operating costs have risen steadily, but even if they do not continue to rise it will cost $5 billion to keep the mentally ill in hospitals for the next ten years. In 1951 $5 million were available for mental research. This amounted to $4.50 per mental patient under treatment compared with $28.20 for infantile paralysis, $26.80 for tuberculosis, and $27.70 for cancer patients.

GRANTS FOR PRACTICAL NURSE EDUCATION

Four foundations (Samuel H. Kress Foundation, New York Foundation, Milbank Memorial Fund, Jesse Jones Foundation) have made grants amounting to $73,000 to the National Association for Practical Nurse Education to finance a three-year study designed to help meet the urgent need for increased nursing service in the homes of patients. Demonstration centers for the project are the Montefiore Hospital School of Practical Nursing, New York City; the University of Houston (Texas) School of Practical Nursing; and the Florence Cook School of Practical Nursing, Kansas City Medical Center (Kansas). The students in the three demonstration schools will spend one month of the one-year training period in the homes of patients. The findings of this study will be used to develop a blueprint for action that can be used by all accredited schools of practical nursing.

FCDA PROVISION FOR FIRE FIGHTING IN ATOMIC ATTACK

The Federal Civil Defense Administration is stockpiling 450 miles of emergency-type pipe line units to supply water for fire fighting and other vital services in the event of enemy air attack. The units can be laid on ground surfaces in a short time to draw water from rivers, lakes, and reservoirs and can be hooked up to existing water mains and street hydrants. Where water so supplied is to be used for medical and household purposes water filters will be employed under the direction of qualified personnel. Each unit includes 3,500 feet of pipe and can carry 1,500 gallons or more water a minute.

TUBERCULOSIS MEETINGS

Joint annual meetings of the National Tuberculosis Association, the American Trudeau Society, and the National Conference of Tuberculosis Workers were held in Boston, May 26-29. More than 2,000 people —physicians, nurses, and lay health workers— from the United States, Canada, Europe, and South America attended the sessions.

At a special session on the new drug isonia-

zid (isonicotinic acid hydrazide) Dr. James E. Perkins, managing director of the NTA, warned that although the drug appears to be extremely helpful in fighting tuberculosis it could actually prove a step backward if "the drug is used indiscriminately by physicians on ambulatory patients, with spread of the infection from these patients to others and with development of widespread strains of tubercle bacilli resistant to the drug." It could also be detrimental if its use brings about an unwarranted decrease in funds for tuberculosis control programs and a reduction of emphasis on other methods already proven to be effective in treating tuberculosis. Isoniazid is relatively inexpensive to produce, is easy to administer, and does not appear to have severe toxic reactions. However, tuberculosis germs resistant to the new drug have already been detected. Actually the new drug has been in use for too brief a time for a true evaluation of its role in tuberculosis treatment.

The relative effectiveness of other drugs used for controlling and treating tuberculosis was also discussed. William Steenken, Jr., head of the Trudeau Laboratory, reported that a vaccine prepared from live but avirulent tubercle bacilli such as BCG was superior to the vaccines tested which were made from dead germs. BCG is the agent most generally used for vaccination against tuberculosis but it is not considered to be a perfect immunizing agent because it does not offer complete protection and because it cannot be stabilized.

In a session on surgery in tuberculosis it was emphasized that drug "coverage" is making the removal of the entire lung or a part of a lung an increasingly safe and effective procedure. Prior to drug therapy resection was a less common surgical procedure in tuberculosis than thoracoplasty.

The enforced hospitalization of recalcitrant patients with active tuberculosis was taken up. According to Dr. Cedric Northrop, tuberculosis control officer, Washington State Department of Health, the "lock and key" method has proved successful. He said, "The forcible isolation of recalcitrant tuberculous patients has not resulted in generating a group of bitter, antagonistic people. On the contrary, almost all of the patients isolated by legal measures have proved to be tractable and capable of being managed when they learned they could be restrained if they failed to cooperate." The employment of simple psychiatric technics such as discussion, explanation, reassurance, suggestion, education, and reeducation was also advocated to cut down the number of AWOLS among tuberculosis patients.

A more realistic governmental policy toward the admission of displaced persons with tuberculosis to the United States was urged by Dr. Robert E. Plunkett, assistant commissioner, tuberculosis control, New York State Department of Health. A federal law prohibits such people from entering this country. Dr. Plunkett suggested that funds be appropriated to establish centers, particularly in Germany and Austria, for the observation and care of the tuberculous. This would not only help to furnish medical care and prevent the spread of infection but would also help to decrease the number of individuals who require tuberculosis hospitalization after they have been approved for admission to the United States.

Tuberculosis among the American Indians was discussed. The death rate from the disease among Indians is five times as high as it is in the rest of the population of the United States. Health conditions among the Indian tribes are related directly to the educational progress of the tribes. Today Indians are being turned away from tuberculosis hospitals and the children are being turned away from schools.

NOPHN FIELD SCHEDULE—JULY

Grace K. Luby	Biloxi, Miss. Nashville, Tenn.
Jean South	East Aurora, N. Y.
Judith E. Wallin	Duluth, Minn. Superior, Wis. Port Huron, Mich. Holland, Mich. Sheboygan, Wis. Highland Park, Ill. South Bend, Ind.
Marjorie L. Adams	Southbridge, Mass. Springfield, Mass.

Our Readers Say . . .

FROM NORWAY

I returned to Norway in the summer of 1949 after having had one year of study in America under an American Red Cross scholarship.

On my return I accepted the position of director of the school of nursing and nursing services at Drammen Hospital. Drammen is a town of 30,000 inhabitants, one hour by train from Oslo. The hospital has 370 beds and is owned by the municipality, but serves patients from the rural districts as well. The school is a Red Cross school of nursing with a three-year program. We have about ninety students and admit seventeen twice a year. In addition we admit twelve students for a one-year program in mother and child care.

My experience in America has been of great value to me since my return to this country. I will try to point out the methods which I have been able to put into effect which have worked successfully. From the very beginning I had regular staff meetings. In these meetings we discuss problems and teaching methods in the wards and work out policies and outlines, and I take the opportunity to keep the staff informed of new trends in the school. I am glad to say that we have all realized the great importance and value of these discussions and have seen how the meetings have resulted in greater cooperation among the staff.

The students had their own council which has now been reinforced. They have profited by the new ideas I brought from American schools, where I learned the importance of cooperation between students and administration, as I believe in democratic leadership. This experiment with extended self government has led to a feeling of more satisfaction and more responsibility among the students and I believe it helps to open their eyes to the necessity of some authority.

When I was in the University Hospital in Minneapolis I had the opportunity of observing the work of the clinical instructors in the ward and learned the great value of this teaching method. More and more leading hospitals in Norway today are employing clinical instructors. We have two in our hospital. We established a blood bank at our hospital in the fall of 1951 and my visits to the American and Canadian Red Cross blood banks were of great profit to me at that time.

As a result of having taken a course in home nursing at Red Cross headquarters in Washington, D.C., I had the opportunity to teach some courses in home nursing at the local Red Cross chapter here which have met with great enthusiasm. My personal contact with Red Cross personnel in America and Canada and the understanding I gained of the organization and program of the Red Cross have been of tremendous interest and help to me and have helped to give me a clearer idea of the work of the International Red Cross. I lecture on this subject in the nursing school and the students are tremendously interested in national and international Red Cross Work. One of my former students is the leader of Junior Red Cross in Drammen and is doing good work.

I found the study program excellent. It met my needs completely and I daresay I profit from it every day in my work. I want once more to express my sincere gratitude to the American Red Cross. It was a privilege to have had this experience.

ESTHER SANNUM, Director
School of Nursing and Nursing Service
Norwegian Red Cross Hospital
Drammen, Norway

NFIP SAYS THANKS

It is with deep appreciation that the National Foundation for Infantile Paralysis thanks the nurses for their untiring efforts and willingness during 1951 to provide the good care so essential to the recovery and wellbeing of the poliomyelitis patient.

The American public has generously supported the fight against poliomyelitis with its dollars which are used, in part, to support the supplementation of nursing services. Without the cooperation of all nurses to accept assignments as the need arose we at the National Foundation headquarters feel our obligation to furnish good care to these patients would have been greatly hampered.

We know that the thousands of patients and their families who have benefited through this service join us in thanking all nurses who have helped to provide poliomyelitis patients their optimum chance of recovery.

BASIL O'CONNOR
President, NFIP

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U. S. AIR FORCE

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QUALIFIED NURSE: Generalized public health nursing program; salary determined by education, experience; salary increments; Social Security; good personnel policies; suburban location, 13 miles from New York; interview by appointment. Write to Miss Lillian A. Ford, Assistant Director, Visiting Nurse Association of the Oranges and Maplewood, 439 Main Street, Orange, New Jersey.

PUBLIC HEALTH NURSES: Civil Service positions open in the Detroit area; salary $3,896 to $4,256 a year, automatic annual salary increases; 40-hour week; annual paid vacations; paid sick leave; liberal retirement plan. For application or further information write to Wayne County Civil Service Commission, 2200 Cadillac Tower, Detroit 26, Michigan.

PUBLIC HEALTH NURSE: Bedside nursing and tuberculosis program; salary based on education and experience; liberal personnel policies. Write to Director, Atlantic Visiting Nurse and Tuberculosis Association, 2332 Pacific Avenue, Atlantic City, New Jersey.

PUBLIC HEALTH NURSES: General rural program; salary, public health nurses, $2,852-$3,560, graduate nurses as assistant PHNs, $2,540-$2,972; travel allowance 6c a mile; 5-day week, vacation, sick leave, and retirement benefits. Write to Mrs. Earle W. Gibbs, State Health Department, Richmond, Virginia.

PUBLIC HEALTH NURSES: Generalized program; urban and rural area; 3-week annual vacation; sick leave; retirement benefits; 7½c a mile travel allowance; 5-day week; salary range $290-$330. Write to D. D. Carr, M.D., Clark County Health Department, Las Vegas, Nevada.

PUBLIC HEALTH NURSES: Generalized service; 37-hour week; excellent personnel policies; city car. Write to Miss J. P. Egbert, Bureau of Health, Binghamton, New York.

SUPERVISOR: City health department; public health degree required; generalized nursing program; salary $4,200 a year; travel allowance $30 a month; state qualifications and experience. Apply to Mr. H. Zinkel, Chairman, Board of Health, 918 South 24 Street, Manitowoc, Wisconsin.

HEALTH EDUCATION SUPERVISOR: City health department; well rounded health department combined with visiting nurse association; excellent staff; salary range $3,600-$4,416; retirement; requirements: 2 years experience and B.S. degree in public health nursing. Write to Nursing Supervisor, 604 City Hall, Spokane, Washington.

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SENIOR PUBLIC HEALTH NURSES: generalized urban program; salary range $3,300 to $3,600; travel allowance $60 a month; 5-day week, 2 weeks vacation, cumulative sick leave; good retirement; liberal personnel policies; opportunity for advancement. Write to Olivia Smythe, R.N., Director of Public Health Nursing, Dallas, Texas.

PUBLIC HEALTH NURSE: Position open September; county visiting nurse association; salary $260-$285; mileage allowance; 4 weeks vacation; Social Security; good personnel practices. Apply to Visiting Nurse Association of Orange County, 1104 West Eighth, Santa Ana, California.

DIRECTOR: position open July 1; staff: 1 supervisor, 7 staff nurses, 2 clerks; NOPHN requirements; retirement plan; good personnel policies; program includes bedside care, tuberculosis, maternity services; student program; beginning salary dependent on training, experience. Write to Chairman, Nursing Committee, Woonsocket Public Health Nursing Association, 99 Main Street, Woonsocket, Rhode Island.

EDUCATIONAL DIRECTOR: voluntary agency; Southern city; generalized program; graduate and undergraduate students accepted for field experience; requirements: B.S. in public health nursing, experience in visiting nursing; 40-hour week, 1 month vacation; automobile not required. For details write to Director, Visiting Nurse Service, 300 West York Street, Norfolk, Virginia.

STAFF NURSE: generalized public health nursing program established over a 10-year period; salary $250-$297, depending upon qualifications and experience. Apply to Director, Lawrence County Health Department, Lawrenceville, Illinois.

PUBLIC HEALTH NURSES: New York City Department of Health; immediate appointment on provisional basis; generalized service includes maternal and child care, school health and communicable disease control; starting salary $2,930, 37-hour week, liberal vacation and sick time allowance, pension rights; inservice training; applicants (except New York State veterans) must not have reached 36th birthday. Write to Bureau of Public Health Nursing, City Health Department, 125 Worth Street, New York 13, N. Y.

PUBLIC HEALTH NURSE: Generalized program; active nursing advisory committee; in Rice County; salary dependent upon experience. Write to Mrs. Clifford Lockwood, Sr., Faribault, Minnesota.

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Books

(Continued from page 474)

The following pamphlets are distributed by the National Dairy Council, Chicago 6. Each is delightfully illustrated, some by line drawings, some by water colors, et cetera, and the first three are designed to attract the very small fry.

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CATALOG, MENTAL HEALTH PAMPHLETS AND REPRINTS AVAILABLE FOR DISTRIBUTION, 1951. Public Health Service Publication 19. Publications and Reports Branch, National Institute of Mental Health, Washington 25, D.C., U. S. Government Printing Office. 3rd edition. 1951. 53 p. 25c.

PUBLIC HEALTH

YOUR NEIGHBOR'S HEALTH IS *Your* BUSINESS. Albert Q. Maisel. New York, Public Affairs Committee, Inc. 1952. 31 p. 25c; special quantity rates. This pamphlet describes the methods by which citizens can work to obtain protective services for their communities. It offers a "yardstick" for measuring the efficiency of a local health department and gives a list of seven basic responsibilities of a health department—controlling communicable diseases, enforcing sanitary regulations, operating prenatal clinics and child health centers, maintaining testing laboratories, fighting chronic diseases, conducting a continuous health education program, keeping accurate health records for the community.

NURSING EDUCATION

THE ORGANIZATION OF HOSPITAL NURSING SERVICES. Charlotte Seyffer, R.N., M.S. in N.Ed., editor. Washington, D.C., The Catholic University of America Press. 1952. 148 p. $2.75. Proceedings of the workshop on the organization of hospital nursing services, conducted at The Catholic University of America, June 12-22, 1951, in an effort to provide an opportunity for professional nurses who are interested in the administration of nursing service programs in hospitals to work together on problems of common interest.

SUPERVISOR OF NURSES and STAFF NURSE: salary for supervisor $4200-$4500 depending on qualifications and experience, starting salary for staff nurse $3340; car furnished or liberal allowance granted if driving own car; pension system, vacation, and sick leave. Contact Mr. Edward Peters, Acting Health Officer, City Hall, La Crosse, Wisconsin.

DIRECTOR OF NURSES: Demonstration voluntary agency in process of expansion; nursing staff expected to be about 25 to 35; combination nursing service now being planned; opportunity for teaching; starting salary $4,500-$5,500, depending upon qualifications; experience in supervision and bachelor's degree required, MPH or master's desirable; excellent personnel policies. Write to Bernard M. Blum, M.D., Director, The Fife-Hamill Memorial Health Center, Seventh and Delancey Streets, Philadelphia 6, Pennsylvania.

PUBLIC HEALTH NURSE: certificate required; generalized program in both urban and rural communities of San Francisco Bay area; salary $291 a month to a maximum of $356 in 5 years; car furnished. Write to Alameda County Health Department, 576 Callan Avenue, San Leandro, California.

PUBLIC HEALTH NURSES: generalized program in suburban area; staff education and student program; 5-day week; vacations; sick leave; retirement benefits. Write to Jack H. Foster, Personnel Director, The Court House, Arlington, Virginia.

PUBLIC HEALTH NURSE: generalized program in city health department; salary $295 to $345; 5-day week; paid vacation; sick leave; retirement; car furnished; registration in California as RN and PHN and driver's license required. For further details write to Fannie Warncke, Director of Nursing, City Hall, Oakland, California.

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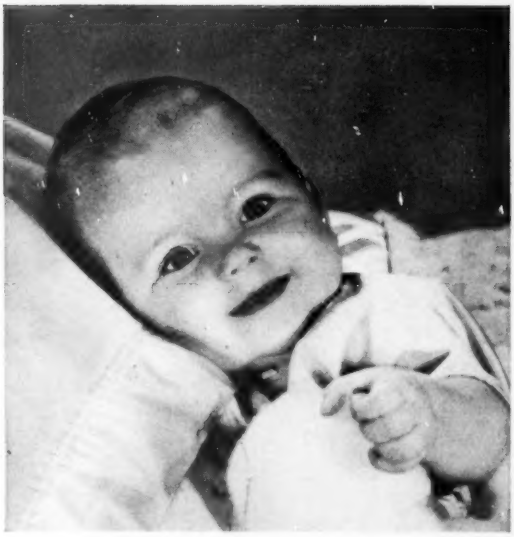

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